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The HIV Positive Health Care Clinician

Rights, Obligations, and the Academy

Sherman L. Cohn, J.D.

On Point

The questions raised by a case of an HIV positive student-clinician in an acupuncture school provide an analytical framework for considering the many conflicts raised by HIV positive health care providers in general. A number of conflicting social values are discussed in the context of federal and Maryland state law. HIV positive people are protected by certain antidiscrimination laws, provided they do not pose a significant risk of transmission. This protection must be balanced against the rights of patients to informed consent, the relative risk of a relatively noninvasive procedure such as acupuncture, and the academic freedom of the school to determine the qualifications of its graduates and the methods by which they are educated. This evaluation and balancing of competing values on a case by case basis provides the most rational and effective policy for dealing with infected providers.

The following paper is taken from an extensive opinion letter prepared for the Traditional Acupuncture Institute, a school for the education and training of acupuncturists in Columbia, Maryland. A student at the Institute who is HIV positive is about to enter clinical training as a part of the educational process. Although the paper is prepared in the context of a student-clinician in an acupuncture school, the author believes that the principles developed and the values discussed are equally valid to all health care workers and provide an analytical framework for consideration of how to treat all HIV positive health care workers.

The discussion to date has focused mainly upon the HIV positive surgeon and dentist, who are thought to provide a greater risk because each works inside an open wound or cavity of the patient, where there are present sharp instruments on which it is possible for the surgeon and dentist to be cut and release his or her own blood to mingle with the blood of the patient. Although there is some doubt as to the reality of that risk, it at most poses a risk greater than that posed by other health care workers who do not work inside open wounds or cavities of patients. It is believed that the analytical framework is the same, although, with enhanced risk thrown into the analytical balance, the

result may be different than the result with health care workers other than surgeons and dentists.

This paper also includes a discussion of the role of the academy, as the particular problem considered was a student-clinician in a professional level school. The analytical framework presented, however, would appear to be valid in any setting of the employment of an HIV positive health care worker and at least helpful to the health care worker who is in a private practice of his or her own and deals directly with a patient who comes to him or her for health care.

Further, the paper focuses upon the state law of Maryland as well as an ordinance of the county in which the acupuncture school is located. Although there will be variations in state and county law, and many probably do not have law as specific as that found here, this discussion was left in the paper as an illustration of the problems that can be posed by local law. The federal law discussion, of course, is equally applicable throughout the United States.

Finally, it must be recognized that both the scientific knowledge and the law in this area continue to develop. Since the preparation of this paper, there have been developments in both arenas. Some of these developments are discussed in an extensive postscript to this paper. Furthermore, even the postscript was completed before the publication of new guidelines from the Centers for Disease Control. These new guidelines are expected at any time. It is currently expected that the new CDC guidelines will be limited to surgeons and dentists. [Note: these new guidelines were published in the *Federal Register* on July 12, 1991, after the completion of this article.]

This opinion is based upon the following factual assumptions:

1. A student now at the college is HIV positive. He has advised the college of this fact. This advice has been circulated to all other students, faculty, and staff either by the student or by the college with the concurrence of the student. Although it is unknown how much further the student has

made his condition known, it is clear that he has made no effort to keep his condition confidential from the college community.

2. Today's scientific knowledge is clear that HIV is infectious, but that the infection is transmitted through blood and blood products, sexual contact, and perinatally from a mother to her fetus. But only someone already infected with HIV can transmit the virus, and transmission must be direct (i.e., blood to blood, blood to mucosal membranes, etc.). It cannot be transmitted through casual contact or through airborne particles.

3. The college practices generally accepted procedures to prevent the spread of infection to patients. In particular, no needles are to be used in more than one person. The college uses disposable needles in all but a very small number of procedures where disposable needles are not available. Where a nondisposable needle is utilized, the college sterilizes that needle in an autoclave before it is used again. Such sterilization procedures are adequate to prevent the transmission of HIV as well as hepatitis and other diseases. The college's rules also provide that no practitioner shall treat a patient if the practitioner has any exudative lesions. Moreover, the college insists that all lesions, even microlesions, be securely covered by bandage or bandaid. Upon the following of these universal precautions, there is no realistic threat of transmission of an HIV infection from practitioner to patient.

4. Some people, probably many people, are emotional and irrational on the subject of AIDS. Thus, although rationally there may be no realistic threat of transmission, some people still exhibit emotional and psychological trauma due to irrational fears of transmission. This emotional and psychological trauma is real and can lead to symptoms that are also real.

It must be recognized at the outset that government at various levels has undertaken to lessen the impact on the HIV positive and even active AIDS patient of the emotional and irrational fears of transmittal of AIDS. This has been attempted by the federal government through the Rehabilitation Act of 1973, which has been applied by the Supreme Court to a matter of health (tuberculosis), and by lower courts to persons who are HIV positive. More recently, Congress has expanded this attempt in the Americans with Disabilities Act of 1990 (ADA). The State of Maryland has undertaken this attempt by statute, and Howard County has aimed at the same result through its Human Rights ordinance. That ordinance has been applied by the Howard County Human Rights Commission to bar discrimination against a person on the ground that he is HIV positive.

It must also be recognized that any health care procedure, including acupuncture, can be performed on a patient only with the informed consent of that

patient. And in Maryland the law bestows on the practitioner the duty of advising the patient of everything, including every risk, that a reasonably prudent patient would need to know to make an informed and intelligent decision. There are now pending at least three cases in a Maryland Circuit Court against Johns Hopkins University Hospital that raise the issue whether, before operating on a patient, a surgeon, as a part of obtaining the informed consent of the patient, must advise the patient that he, the surgeon, is HIV positive. Each of those cases has been brought by a former patient who is not HIV positive and thus presents no evidence of actual transmission of HIV.

Finally, the federal Centers for Disease Control has recognized that there is a dentist who was HIV positive and who probably transmitted HIV to one, and possibly five, patients. Although this is the only known probable transmittal from an HIV positive health care worker to a patient, it has led the American Medical Association and the American Dental Association to issue new guidelines for the conduct of HIV positive health care workers and for the Centers for Disease Control to reconsider its guidelines issued in 1987.

Each of these matters must be considered in some depth in arriving at a decision as to conduct that is legally prudent. But there is still more that must be considered: the broader ethics that takes into consideration the HIV positive student, the well-being of the patient, the college, its teaching mission and its broader community, and the healing process that is the reason that the patient comes to the college, that the student is enrolled at the college, and that represents the college's very *raison d'être*.

I. Governmental Regulation: Protection of the Handicapped

There is no basis for considering legal rights of the HIV positive student aside from those provided by federal, state, or county legislation. The college is a private, nongovernmental entity, and thus is not subject to any direct federal constitutional restrictions on its actions. Nor are there any applicable provisions of the Maryland constitution. Thus, any restrictions on the action that the college, in its considered judgment, believes to be best in its treatment of this or any other student must be found in statute or regulations, as construed by courts.

A. Federal Statute

The two applicable federal statutes are the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990. As these statutes may apply differently to the current HIV positive student and to future students in a like situation, they must be considered separately.

1. The Rehabilitation Act of 1973. As amended through 1988, the Act declares its purpose to be "to

develop and implement, through . . . the guarantee of equal opportunity . . . and independent living, for individuals with handicaps in order to maximize their employability, independence, and integration into the workplace and the community."¹

Section 504 of the Act² declares that "No otherwise qualified individual with handicaps . . . shall, solely by reason of her or his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance . . ."

There are several factors here that must be explored. First, we must consider what is meant by a "program or activity receiving Federal financial assistance"; second, who is an "individual with handicaps" within the meaning of this Act; and, third, whether under the "otherwise qualified" language or otherwise, there is any requirement under the Act to accommodate the handicap of the individual.

The Rehabilitation Act does not apply to all educational institutions or all businesses. It applies only to those that "receiv[e] Federal financial assistance." Case law makes it clear that merely being a charitable corporation and thus tax exempt under Section 501(c)(3) of the Internal Revenue Act is not enough to be covered by the Act.³⁻⁵ Case law also makes it clear that, if the clinic or health practitioner receives reimbursement under medicare or medicaid, that is enough "federal assistance" for the Act to apply.^{6,7} And that such a clinic (indeed, in dicta, even a private practitioner in his nonclinic office) may not refuse to perform elective surgery because the patient has symptomatic AIDS.⁸

Finally, there is no case that holds that a school that has a student who has a federally insured student loan, or even receives a direct federal loan or grant, receives such "federal assistance" as to be covered within the Act. And an opinion of the Department of Justice holds that that is not enough.⁹ Of course, should a school receive any federal money for research, staff support, or any other purpose, the Act applies.

Thus, in my opinion, if a school receives no direct federal funding and if its clinic does not receive medicare or medicaid reimbursement, the Rehabilitation Act of 1973 does not apply, even though students in the school may receive federally guaranteed loans or direct loans or grants from the federal government. But, if a school or its clinic receives any federal funding, including medicare or medicaid reimbursement, the Rehabilitation Act does apply.

An "individual with handicaps" is defined by Section 7 of the Act¹⁰ as a person who:

- (i) has a physical or mental impairment which substantially limits one or more of such person's major life activities,
- (ii) has a record of such an impairment, or
- (iii) is regarded as having such an impairment.

The Supreme Court has held that this definition includes a person who is infected with tuberculosis.¹¹

Arline, an elementary school teacher, was held to be handicapped because her tuberculosis had adversely affected her respiratory system, requiring hospitalization. This condition was held to limit substantially

If a school or its clinic receives any federal funding, including medicare or medicaid reimbursement, the Rehabilitation Act does apply.

one of her major life activities and thus brought her within the Act. The fact that she was also contagious "does not suffice to remove [her] from coverage under § 504."¹²

Congress thereafter amended the Act¹³ to provide that the term "individual with handicaps"

does not include an individual who has a currently contagious disease or infection *and* who, by reason of such disease or infection, would constitute a direct threat to the health or safety of other individuals or who, by reason of the currently contagious disease or infection, is unable to perform the duties of the job.

(Emphasis added). This language was added by the Harkin-Humphrey amendment to the Civil Rights Restoration Act of 1988, at least partially in response to Chief Justice Rehnquist's dissent in *Arline* disagreeing with the majority on the ground that Congress in the 1973 Act had not stated that the protection of the Act was extended to those with contagious or infectious diseases.¹⁴

Clearly by necessary implication, Congress ratified the Supreme Court's interpretation of the Rehabilitation Act to apply to a person with a currently contagious disease or infection. And the legislative debates make it very clear that that was the intent of Congress.¹⁵ Also, quite clearly, Congress intended that someone who is HIV positive be covered by the Act. That is, the holding of each of the courts that has considered the issue.¹⁶

While these cases antedated the Harkins-Humphrey amendment, the debates on the passage of that amendment reflect that they correctly read the intent of Congress.¹⁷

There thus can be no doubt that the 1973 Rehabilitation Act applies its protections to persons who are HIV infected. But this raises the question of whether the protection of the Act extends to persons who are HIV infected but are asymptomatic, so that they, in fact, can work, attend classes, and otherwise function. Upon analysis, the answer is in the affirmative.

First, it should be noted that the Surgeon General of the United States, C. Everett Koop, has stated that it is

inappropriate to think of [HIV infection] as composed of discrete conditions such as ARC [AIDS-related complex] or "full blown" AIDS. HIV infection is the starting point of a single disease which progresses through a variable range of stages. In addition to an acute flu-like illness, early stages of the disease may involve subclinical manifestations, i.e., impairments and no visible signs of illness.

On the basis of these facts, the Surgeon General concluded that

from a purely scientific perspective, persons with HIV infection are clearly impaired. They are not comparable to an immune carrier of a contagious disease such as Hepatitis B. Like a person in the early stages of cancer, they may appear outwardly healthy but are in fact seriously ill.¹⁸

Furthermore, the term "physical impairment" within the meaning of "individual with handicaps" has been defined by the Department of Health and Human Services, in its regulations implementing Section 504 of the 1973 Act, as follows:

[A]ny physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin; and endocrine.¹⁹

The United States Department of Justice, in issuing an opinion that an asymptomatic individual who is HIV positive is handicapped within the meaning of this regulation, has pointed to the fact that such an individual will begin to restrict his own activity, particularly in the area of procreation and intimate personal relations, and that in effect is a "physical impairment" within the meaning of the regulation.²⁰

Second, the 1973 Rehabilitation Act does not require an actual physical impairment, but the protection of the Act applies when a person "is regarded [by others] as having . . . an impairment."²¹ This provision was added to the Rehabilitation Act in 1974, Congress clearly intending the protection of the Act to apply to a person who is believed by others to be impaired even if his condition "in fact does not substantially limit that person's functioning."²² The Supreme Court in *Arline* referred to that legislative history and concluded that the Act was intended to apply to protect a person who had a condition that in itself worked no impairment but where it "substantially limit[s] that person's ability to work as a result of the negative reactions of others to the impairment."²³

This construction by the Supreme Court of the statutory definition of the term "individual with handicaps" is particularly relevant to persons who are HIV positive but asymptomatic. The Court found that, in order "to combat the effects of erroneous but nevertheless prevalent perceptions about the handicapped,"

Congress intended by its 1974 amendment to include within the Act's protection persons who are regarded by others as handicapped but who "may at present have no actual incapacity at all."²⁴

The Court in *Arline* stressed that the Act, as amended in 1974, covers persons "who, as a result [of being incorrectly regarded as handicapped], are substantially limited in a major life activity."²⁵ Thus, the Supreme Court read the statute to mean what it says: the perceived impairment need not directly result in a limitation of a major life activity, so long as it has the indirect effect, due to the misperceptions of others, of limiting a life activity. There can be no doubt that this applies to someone who is HIV positive, although asymptomatic. And that has been the determination of at least two lower courts.²⁶

The next question that must be addressed is the requirement of Section 504 of the 1973 Act that, for a person to come under the protection of the Act, he must be "otherwise qualified." Thus, for an individual with handicaps to have the protection of the Act, he must be "able to meet all of a program's requirements in spite of his handicap."²⁷

The Court in *Arline* referred to the statutory "goal of protecting handicapped individuals from deprivations based on prejudice, stereotypes, or unfounded fear, while giving appropriate weight to such legitimate concerns . . . as avoiding exposing others to significant health and safety risks . . ."²⁸ To assess whether "a person handicapped with a contagious disease" is prevented by that disease from being "otherwise qualified," the Supreme Court adopted a four-part analysis suggested by the American Medical Association:²⁹

- (a) the nature of the risk (how the disease is transmitted),
- (b) the duration of the risk (how long is the carrier infectious),
- (c) the severity of the risk (what is the potential harm to third parties),
- (d) the probabilities the disease will be transmitted and will cause varying degrees of harm.

Once this analysis is complete, the Court stated, one must determine whether the employer (and presumably all others who have duties under the 1973 Act) can "reasonably accommodate" the handicapped employee if that is possible without "undue financial and administrative burdens" or without requiring "a fundamental alteration in the nature of [the] program."³⁰

Thus, the Court concluded, "a person who poses a significant risk of communicating an infectious disease to others in the workplace will not be otherwise qualified for his or her job if reasonable accommodation will not eliminate that risk."³¹ Under this analysis, it is clear that a person infected with HIV will not be "otherwise qualified" where there is a significant risk of transmitting the virus to others. But it is also clear that a person infected with HIV will be "otherwise qualified" if there is no significant risk of trans-

mitting the virus to others. The only exception to that statement is in the case of a person who, because of the HIV virus, may suffer a dementia attack and is in a position especially dangerous to others.³²

This construction by the Supreme Court in *Arline* was not altered by the Harkin-Humphreys amendment of 1988. That amendment excludes from the Act's protection

an individual who has a currently contagious disease or infection and who, by reason of such disease or infection, would constitute a direct threat to the health or safety of other individuals or who, by reason of the currently contagious disease or infection, is unable to perform the duties of the job.³³

The legislative history is clear that Congress intended to place into the statute the *Arline* requirement of reasonable accommodation in determining whether a person is otherwise qualified.³⁴ Even the opponents agreed that this was the intent of the amendment.³⁵

I, therefore, conclude that the Rehabilitation Act provides duties only to employers or other persons who receive federal funds, which includes medicare and medicaid reimbursements but does not include the enrollment of students who receive federal loans or federally insured loans. Furthermore, the Act provides protection to a person infected with HIV, whether or not he or she is symptomatic, assuming, of course, that that person is otherwise qualified. In determining whether an HIV-infected person is otherwise qualified, the program must consider whether the person infected would cause a direct threat of infection to others, and, if so, whether a reasonable accommodation of that person can be made so as to permit that person to continue in his job or education without being that direct threat.

2. The Americans with Disabilities Act of 1990. The ADA extends the impact of what already was law—the Rehabilitation Act of 1973—virtually to all employment and public accommodations, whether or not the entity receives federal funding. This is the Act's principal change as far as the present inquiry is concerned. It makes no change to the definition of an "individual with a disability" developed above.³⁶

However, it should be noted that, in the ADA, Congress again makes a strong and clear statement that it is national policy to eliminate discrimination against the handicapped:

(1) to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities;

(2) to provide clear, strong, consistent, enforceable standards addressing discrimination against individuals with disabilities;

(3) to ensure that the federal government plays a central role in enforcing the standards established in this chapter on behalf of individuals with disabilities; and

(4) to invoke the sweep of congressional authority, including the power to enforce the Fourteenth Amendment and to regulate commerce, in order to address the major areas of discrimination faced day to day by people with disabilities.³⁷

It should also be noted that the Act does not go into effect until July 1992 for employers who have 25 or more employees and until July 1994 for employers who have 15 to 25 employees. The public accommodations section does not go into effect until January 1992. Thus, the ADA has no application to a pending controversy, though it must be considered in reflecting upon national policy and in drafting policy for future application.

The ADA makes no change in the definition of an "individual with handicaps." As concerns employment of individuals with handicaps, the ADA expressly puts into statutory law the "reasonable accommodation" concept that *Arline* read into the Rehabilitation Act.³⁸

The ADA also makes explicit, in banning discrimination against an individual with handicaps in public accommodations, that the following are public accommodations for this purpose:

- (F) . . . professional office of a health care provider, hospital, or other service establishment;
- (J) a nursery, elementary, secondary, undergraduate, or post graduate private school, or other place of education . . .³⁹

Thus, there is no doubt that, as far as students (or patients) are concerned, a school to educate or train health-care providers, including acupuncturists, and a clinic for the practice of any health care, including acupuncture, will be covered under the ADA public accommodation provisions, as of January 1992, regardless of its number of employees.

The general rule concerning public accommodations is:

No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to) or operates a place of public accommodation.⁴⁰

The Act prohibits (a) denying an individual on the basis of a disability "of the opportunity . . . to participate in or benefit from the goods, services, facilities, privileges, advantages, or accommodations," or (b) providing that opportunity on a basis "not equal to that afforded to others," or (c) providing that individual with a benefit "different or separate from that provided to other individuals, unless such action is necessary to provide" the handicapped individual with an "opportunity that is as effective as that provided to others."⁴¹

There are two specific provisions that are pertinent here. First, the Act provides that discrimination

in public accommodation includes

(i) "application of eligibility criteria that screen out or tend to screen out an individual with a disability," or

(ii) "a failure to make reasonable modifications in policies, practices, or procedures, when such modifications are necessary to afford such goods, services, facilities, privileges, advantages, or accommodations to individuals with disabilities," or

(iii) "a failure to take such steps as may be necessary to ensure that no individual with a disability is excluded, denied services, segregated or otherwise treated differently than other individuals because of the absence of auxiliary aids and services" —

in each case unless such criteria, modifications or steps "can be shown to be necessary for the provision of" or "would fundamentally alter the nature of the goods, services, facilities, privileges, advantages, or accommodations," or, solely in the case of (iii) "would result in an undue burden . . ."⁴²

Second, the Act provides explicitly:

Nothing in this subchapter shall require an entity to permit an individual to participate in or benefit from the goods, services, facilities, privileges, advantages and accommodations of such entity where such individual poses a direct threat to the health or safety of others. The term "direct threat" means a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures or by the provision of auxiliary aids or services.⁴³

In sum, the ADA will extend the federal prohibitions making illegal discrimination of persons with disabilities. The employment provisions will apply as of July 1992 to employers of 25 or more employees and as of July 1994 to employers of 15 to 25 employees. The public accommodation provisions will apply as of January 1992. And there is no doubt that the public accommodation provisions prohibit discrimination against students in any health care program, including those of acupuncture.

Moreover, under the ADA the definition of "individual with handicaps" has not changed, so it continues to encompass those persons who are infected with HIV. And the employment provisions continue the concepts of "otherwise qualified" and "reasonable accommodation," and indeed write them into the very statute. Finally, there is no doubt that the public accommodation provisions require reasonable modification of facilities, screening criteria, policies, programs, etc., to accommodate a person with a disability, as long as that does not "fundamentally alter" the service being offered, unless "a significant risk to the health and safety of others" cannot be eliminated even by such modifications.

B. State Requirements

Many states have statutes that govern this area. Maryland is among them. Article 49B of the Maryland Code prohibits discrimination in public accommodations (Section 8) and in employment (Sections 14-17) on the basis of "physical or mental handicap." The term "physical or mental handicap" is defined by Section 15(g) as:

any physical disability, infirmity, malformation or disfigurement which is caused by bodily injury, birth defect or illness including epilepsy, and which shall include, but not be limited to, any degree of paralysis, amputation, lack of physical coordination, blindness or visual impairment, deafness or hearing impairment, muteness or speech impediment or physical reliance on a seeing eye dog, wheelchair, or other remedial appliance or device; and any mental impairment or deficiency as, but not limited to, retardation or such other which may have necessitated remedial or special education or related services.

The Maryland Commission on Human Relations, which has the authority to enforce this statute, has redefined the term "physical or mental handicap" to include specifically "infection with the Human Immunodeficiency Virus . . ."⁴⁴ Furthermore, the commission regulations contain an "explanation" that the term "handicap" applies not only to a person who is, in fact, handicapped, but also to a person who

is regarded as having such a handicap. This refers to those individuals who are perceived as having a handicap, whether an impairment exists or not, but who are regarded as handicapped by persons who have or may have an effect on the individual's securing housing or public accommodations, or securing, retaining, or advancing in employment, or all of these.⁴⁵

The Commission also provides that "an employer must attempt to make a reasonable accommodation to" the handicap, "unless the employer can demonstrate that this accommodation would impose an undue hardship on the employer's business," considering the size of the business, the type of business, and the nature and cost of the accommodation needed.⁴⁶

The prohibition against discrimination in public accommodations is limited to those persons, businesses, corporations, etc., which are licensed or regulated by the Maryland Department of Licensing and Regulation (Art. 49B, Sec. 8). The Human Rights Commission requires that "reasonable accommodation for the needs of the handicapped be undertaken," with a list of physical changes given as illustrative.⁴⁷

No court cases under this statute have been found.

C. Howard County Requirements

Howard County has enacted an ordinance: the Human Rights subtitle of the Health and Social Serv-

ices title of the Howard County Code.⁴⁸ This subtitle provides in its policy statement:

The Howard County Government shall foster and encourage the growth and development of Howard County so that all persons shall have an equal opportunity to pursue their lives free of discrimination.

This statement continues: "Discrimination practices based upon . . . Physical or mental handicap . . . [are] contrary to the public policy of Howard County."⁴⁹ The term "physical or mental handicap" is defined as "a physical or mental condition" which:

- (a) Substantially limits one or more of a person's major life activities;
- (b) Is historically a part of the person's record; or
- (c) Is regarded as an impairment.⁵⁰

Thus, the policy of Howard County is clear. And in a decision rendered October 4, 1990, the Howard County Human Rights Commission held that the condition of being HIV positive is a handicap within the meaning of this ordinance.⁵¹

Therefore, any discrimination in Howard County against a person who is HIV positive would violate the ordinance—as long as it comes within the ordinance.

However, this is not the end of the consideration. A reading of the ordinance finds that it applies to the following situations:

- (a) Sec. 12.207. Unlawful housing practices.
- (b) Sec. 12.208. Unlawful employment practices.
- (c) Sec. 12.209. Unlawful law enforcement practices.
- (d) Sec. 12.210. Unlawful public accommodations practices.
- (e) Sec. 12.211. Unlawful financing practices.

There is nothing by which the ordinance applies expressly to educational institutions, except in their role as an employer or as they furnish housing, or in their public accommodation role, as a clinic would be to patients who are members of the public.

There are two possible arguments that might be made for the application of the ordinance. First, it might be argued that a clinician is an "employee" within the meaning of the employment practices section. The term "employee" is defined, quite unhelpfully for our purposes, as "an individual employed by an employer." The only mention of educational institutions is to exempt from the requirements of the ordinance educational institutions "in hiring and employing persons of a particular religion if the school, college or educational institution is . . . owned, supported, controlled or managed . . . by a particular church, synagogue, or other religious organization . . ."

The entire tenor of the provisions concerning employment appears to contemplate its application to traditional employment situations, or apprenticeships

toward employment, rather than clinical training as a part of an educational program. If the ordinance did apply to clinical training, then the only apparently relevant provision makes unlawful discrimination which "limits, segregates, classifies or assigns employees." However, there is also a provision which exempts from being unlawful "bona fide occupational qualifications . . . reasonable, necessary and relevant to the normal operation of the particular business or enterprise . . ." Thus, if a clinical student is an "employee" within the meaning of this Section of the ordinance, the issue would be begged as to whether particular requirements applicable to HIV positive clinical students are "bona fide occupational qualifications."

The second argument that might be made is that the college is a "public accommodation vis a vis its students, in that it "holds itself out as inviting the public to utilize its . . . services" when it advertises or otherwise holds itself out to persons to apply for admission. The Howard County Human Rights Commission has taken an expansive view of what is public accommodations. In the commission decision cited above, the complainant had called the Howard County Medical Society Physician Referral Service, advising a Ms. Davis, the Secretary of the Medical Society and the person who answered the telephone, that he, the caller, was infected with HIV and that he sought a referral to a local physician for routine and emergency care (as distinct from treatment for his HIV infection, for which he already had a physician). Ms. Davis advised the caller that "none of the[] physicians [on the referral list] would accept an HIV positive patient." The commission held that the physician referral service is a "public accommodation" within the meaning of the ordinance:

[T]he Panel finds that the spirit of the law is that services that are offered and made available to the public whether or not for profit should operate in a non-discriminatory fashion. In today's society, a number of services are provided by telephone and, therefore, it is believed that a "place" does encompass a more expansive definition than a mere physical location and does include telephonic communications particularly as in this case where the caller and receiver are both located in Howard County. The Panel further finds that this expansive definition is in keeping with the broad public policy of eradicating discrimination from our society. Additionally, the history of anti-discrimination legislation appears to have been one of constantly expanding coverage.

From this decision, it must be concluded that it would not at all be surprising for the commission to hold, as well, that "education" offered in Howard County to members of the public who are invited to apply for admission falls within the "public accommodation" provision of the ordinance. To be clear, it is not at all certain that the Commission would arrive at this conclusion, nor that a court, upon appeal from

such a holding, would uphold it. But it is also not at all clear that "education" would be deemed excluded from the ordinance as it now reads.

It should also be noted that there is no provision in the public accommodation section of the ordinance that is equivalent to the provision in the employment section exempting "bona fide occupational qualifications . . . reasonable, necessary and relevant to the normal operation of the particular business or enterprise . . ." It is to be hoped that the commission and the courts will read into the public accommodations section a reasonableness standard. For example, it would be reasonable for an acupuncture school to determine that a person who has no fingers and, thus, is unable to hold a needle, or a person who has Parkinson's disease and hence cannot stop from shaking, would not be eligible to enter the educational program leading to the practice of acupuncture. If that is accepted, then the college is left with the identical question in the present matter: whether requirements specifically applicable to an HIV positive student are restrictions that are reasonable under the circumstances of that condition.

D. Reasonable Accommodation

No matter the language that is used, should any of these statutory requirements apply to the college, the issue becomes whether (a) requirements that are placed on an HIV positive student are bona fide and reasonable accommodations to the handicap of that student, and (b) no accommodation of the handicap is reasonable in that it does not remove the threat to the health and safety of others or, if it does, it would render a fundamental change in the mission of the college. To answer these questions, other values need to be considered: the interests of the patient, the interest of the educational institution, and the known risks of transmission or other relevant danger. We will return to the issue of reasonable accommodation after these values are developed.

II. Informed Consent: The Rights of the Patient

The discussion to this point has centered on the rights of the individual with handicaps, with a particular focus upon a person whose handicap is an HIV infection. The factual situation in which this matter arises, however, requires a focus upon the HIV positive person who is a health care provider and who practices a health care procedure upon a patient. This begs the issue of what rights the patient may have in this situation.

The patient's rights can best be examined in terms of a court-developed doctrine called informed consent. An examination of that doctrine and the values behind it are important to this analysis.

A fundamental principle of American jurisprudence, in the words of then Judge Cardozo, is that "every human being of adult years and sound mind

has a right to determine what shall be done with his own body."⁵² From this root principle flows "the universally recognized rule that a physician, treating a mentally competent adult under nonemergency circumstances, cannot properly undertake to perform surgery or administer other therapy without the prior consent of his patient."⁵³ Further, "it is the prerogative of the patient, not the physician, to determine for himself the direction in which his interests seem to lie."⁵⁴

For there to be consent, in any real sense, the patient must be informed: "To enable the patient to chart his course understandably, some familiarity with the therapeutic alternatives and their hazards becomes essential."⁵⁵

[I]t is evident that it is normally impossible to obtain a consent worthy of the name unless the physician first elucidates the options and the perils for the patient's edification. Thus the physician has long borne a duty, on pain of liability for unauthorized treatment, to make adequate disclosure to the patient.⁵⁶

As the Maryland Court of Appeals put it in *Sard v. Hardy*, "for the patient's consent to be effective, it must have been an 'informed' consent, one that is given after the patient has received a fair and reasonable explanation of the contemplated treatment or procedure."⁵⁷

These statements, of course, beg the question of how much the health practitioner must disclose. *Sard* provides a general principle:

This duty to disclose is said to require a physician to reveal to his patient the nature of the ailment, the nature of the proposed treatment, the probability of success of the contemplated therapy and its alternatives, and the risk of unfortunate consequences associated with such treatment. [58] . . . The law does not allow a physician to substitute his judgment for that of the patient in the matter of consent to treatment.⁵⁹

Up to this point, there is general agreement among the courts. But there are important elements of informed consent on which there is no agreement. For our purposes, chief among those points of disagreement is whether the scope of the health care practitioner's duty to warn is to be measured by (a) what a careful practitioner believes a patient should know, or (b) what a prudent patient would need to know in order to make an intelligent decision.

The difference is profound, for under the careful practitioner standard, a practitioner is deemed to have informed if he or she tells the patient whatever other practitioners tell their patients in similar circumstances. By this rule, the practitioner's obligation to disclose is a matter committed to professional judgment and discretion.⁶⁰ "According to this view, whether a physician has breached his duty to disclose is determined by what risks a reasonable medical

practitioner would have disclosed under the same circumstances."⁶¹

Under the prudent patient standard, on the other hand, while what practitioners usually do is of some relevance, the focus is on the patients and their need of information:

Any definition of scope in terms purely of a professional standard is at odds with the patient's prerogative to decide on projected therapy himself. That prerogative, we have said, is at the very foundation of the duty to disclose, and both the patient's right to know and the physician's correlative obligation to tell him are diluted to the extent that its compass is dictated by the medical profession.

In our view, the patient's right of self-decision shapes the boundaries of the duty to reveal . . . The scope of the physician's communications to the patient, then, must be measured by the patient's need, and that need is the information material to the decision.⁶²

Maryland has adopted the prudent-patient standard:

[P]rotection of the patient's fundamental right of physical self-determination—the very cornerstone of the informed consent doctrine—mandates that the scope of a physician's duty to disclose therapeutic risks and alternatives be governed by the patient's informational needs. Thus, the appropriate test is not what the physician in the exercise of his medical judgment thinks a patient should know before acquiescing in the proposed course of treatment; rather, the focus is on what data the patient requires in order to make an intelligent decision.⁶³

The values identified by Maryland as underlying this standard are two: first, "the protection of the patient's fundamental right of physical self-determination," and, second, "fundamental fairness":

[S]ince the patient must suffer the consequences, and since he bears all the expenses of the operation and post-operative care, fundamental fairness requires that the patient be allowed to know what risks a proposed therapy entails, alternatives thereto, and the relative probabilities of success.⁶⁴

Under this standard, "the proper test for measuring the physician's duty to disclose risk information is whether such data will be material to the patient's decision."⁶⁵ The practitioner is to advise the patient of all material risks of the therapy. "A material risk is one which a physician knows or ought to know would be significant to a reasonable person in the patient's position in deciding whether or not to subject [herself] to a particular medical treatment or procedure."⁶⁶

If the risk would be intolerable for the reasonably prudent patient, he or she is entitled to say no, however unwise that assessment of relative risk may be in the eyes of the health practitioner.⁶⁷ And the patient

is entitled to all the information concerning the risk that is material to making that decision. Risks that are material to that decision depend upon their severity as well as the probability that they would occur.⁶⁸ Professor Gostin of Harvard has concluded, "As the

If the risk would be intolerable for the reasonably prudent patient, he or she is entitled to say no, however unwise that assessment of relative risk may be in the eyes of the health practitioner.

severity of a potential harm becomes greater the need to disclose improbable risks grows, though courts have yet to assign a threshold for the probability of a grave harm beyond which it must be disclosed."⁶⁹

The Maryland Court of Appeals, however, has made clear that a practitioner "is not burdened with the duty of divulging *all* risks, but only those which are material to the intelligent decision of a reasonably prudent patient."⁷⁰ Furthermore, a practitioner is not under a duty "to discuss the relatively remote risks inherent in common procedures, when it is common knowledge that such risks inherent in the procedure are of very low incidence."⁷¹

The Massachusetts Supreme Judicial Court agrees: "Regardless of the severity of a potential injury, if the probability that the injury will occur is so small as to be practically nonexistent, then the possibility of that injury occurring cannot be considered a material factor in a risk assessment . . ." ⁷² In the words of the federal Court of Appeals for the First Circuit, "risks which are 'possible,' but remote or unforeseeable due to their 'negligible' probability of occurrence, are immaterial as a matter of law."⁷³

The practitioner, of course, may "withhold information on therapeutic grounds, as in those cases where a complete and candid disclosure of possible alternatives and consequences might have a detrimental effect on the physical or psychological well-being of the patient . . ." ⁷⁴ Finally, the practitioner's "duty to disclose is suspended where an emergency of such gravity and urgency exists that it is impractical to obtain the patient's consent."⁷⁵

The District of Columbia, in *Canterbury v. Spence*, spelled out these requirements in somewhat different language. First, that court "discard[ed] the thought that the patient should ask for information before the physician is required to disclose . . . Duty to disclose is more than a call to speak merely on the patient's request, or merely to answer the patient's questions: it is a duty to volunteer, if necessary, the information the patient needs for intelligent decision."⁷⁶

Ideally, "exposure of a risk would be mandatory whenever the patient would deem it significant to his

decision," but basing the law upon such a requirement would "summon the physician to second-guess the patient, . . . an undue demand upon medical practitioners . . ." Rather, "liability for nondisclosure is to be determined on the basis of foresight, not hindsight;" with the practitioner being bound to divulge "what he knows or should know to be the patient's informational needs."⁷⁷

The starting point is with the practitioner, "who is in position to identify particular dangers He cannot know with complete exactitude what the patient would consider important to his decision, but on the basis of his medical training and experience he can sense how the average, reasonable patient expectably would react."⁷⁸

The test is "not subjective as to either the physician or the patient; it remains objective with due regard for the patient's informational needs . . ." In general, the court went on,

A risk is thus material when a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy.⁷⁹

In getting down to the nitty-gritty, the court stated that the following topics should be disclosed:

the inherent and potential hazards of the proposed treatment, the alternatives to that treatment, if any, and the results likely if the patient remains untreated. The factors contributing significance to the dangerousness of a medical technique are, of course, the incidence of injury and the degree of the harm threatened. A very small chance of death or serious disablement may well be significant; a potential disability which dramatically outweighs the potential benefit of the therapy or the detriments of the existing malady may summon discussion with the patient.⁸⁰

Turning to the exception to the informed consent requirement where the practitioner concludes that there are therapeutic reasons to withhold information, the court cautioned that that exception "must be carefully circumscribed":

The privilege does not accept the paternalistic notion that the physician may remain silent simply because divulgence might prompt the patient to forego therapy the physician feels the patient really needs. That attitude . . . runs counter to the foundation principle that the patient should and ordinarily can make the choice for himself.⁸¹

Thus, we are left with the following: Maryland requires, with certain extraordinary exceptions, that the patient consent before a therapeutic procedure is undertaken. The patient's consent must be informed. For the patient to give informed consent, he or she must be informed of all the information "so as to

enable the patient to make an intelligent and informed choice about whether or not to undergo" the therapy.⁸² The focus is not upon what the practitioner's profession usually does, but "on what data the patient requires in order to make an intelligent decision."⁸³ Again and again, the Maryland court states that the focus is on "the patient's need" for information "material[] . . . to the decision of the patient," divulging each risk "which a physician knows or ought to know would be significant to a reasonable person in the patient's position in deciding" whether to undergo that therapy. And this is not a duty to divulge all risks, "but only those which are material to the intelligent decision of a reasonably prudent patient."⁸⁴

Thus, the practitioner must put him or herself into the shoes of the "reasonably prudent patient," and ask what information, what risks would be material to that patient in deciding whether to go forward with the therapy. The test is not what the practitioner knows, or what the practitioner thinks that the patient ought to know: it is what the "reasonably prudent patient" needs to know.

The final question that must be asked is whether the practitioner is obliged to convey to the patient information about the practitioner, or whether there is no occasion in which information concerning the practitioner is necessary for consent to be informed.

This issue came up in a case in the United States Court of Appeals for the Fourth Circuit, *Wachter v. United States*,⁸⁵ a case which involved Maryland law. In that case, a patient was operated on at Bethesda Naval Hospital by a surgeon who was hired by the Navy after having been terminated by two civilian health centers for incompetence and lack of diligence, and after having been found unqualified for service in the Air Force because of reduced vision. A Navy report later found that this surgeon had an "unacceptably high" mortality rate while at Bethesda Naval, with a number of deaths that other surgeons opined were due to culpable negligence. He was subsequently cashiered on the ground of dereliction of duty.⁸⁶ The patient sued on the ground that she had not been informed of the surgeon's past when she gave her consent to the surgery. The Court of Appeals affirmed the trial court's conclusion that the unhappy result that the patient suffered from the surgery in question had nothing to do with the surgeon's past or even then present problems; the result was not an unexpected one from the surgery performed. In reaching this ruling, the court noted that the patient sued for lack of sufficient disclosure about the surgeon by either the surgeon and the hospital. The court stated: "We read *Sard* to leave at issue whether revelations of information about one's physician are within the scope of the duty to disclose as Maryland has chosen to define it." Of course, in the way that the *Wachter* court disposed of the case, it too had no reason to decide the issue.⁸⁷

As far as I have been able to find, there are but

two reported cases nationally that even consider whether the "informed consent" duty on the part of the health care practitioner includes a requirement of supplying information about him or herself, as distinct from information about the procedure or therapy and its risks, that a patient might find significant in deciding to go forward with that procedure or therapy. In a Kentucky case, *Piper v. Menifer*,⁸⁸ the court stated:

Suppose a physician, knowing that he has an infectious disease, continues to visit his patients without apprising them of the fact, and without proper precautions on his own part, and thus communicates the disease to one of them? Clearly the physician thus acting would be guilty of a breach of duty, and of his implied undertaking to his patient, which . . . would render him liable for the consequent damage . . .⁸⁹

The suit was by the physician for his fee. The patient defended on the theory that, when the physician was called to treat the patient, he was asked, before he came into the house, whether he was also treating persons ill with smallpox. The physician was also told that, if he were treating persons with smallpox, the patient would call another physician. The physician assured the family that he was not treating persons ill with smallpox. The evidence showed, however, that the physician in fact was treating persons with smallpox. The patient contracted smallpox from the physician. The Kentucky Court of Appeals held that the jury was justified, upon these facts, in not awarding the physician a judgment for his fee.⁹⁰ In the second case, *Hales v. Pittman*,⁹¹ the court held that the physician had the duty to inform the patient of his experience, or lack thereof, before the patient was asked to consent.

The issue, however, is now before the Circuit Court for the City of Baltimore in a case involving an HIV positive surgeon, *Rossi v. Almaraz & Johns Hopkins Hosp.*,⁹² before a New Jersey Superior Court in a case involving an HIV positive surgeon who was permitted to have privileges at a Princeton hospital only if he advised patients in advance of his HIV infection and obtained their consent,⁹³ *Estate of Behringer v. Medical Center*, and before a federal district court in Missouri in a case involving an HIV positive dental student who was not permitted to complete his clinical training, *Doe v. Washington University*.⁹⁴

There is no doubt, however, that many patients would like to know whether their practitioners are HIV positive. This is clear from the *Rossi* suit in Baltimore. In that situation, Mrs. Rossi had been operated on by Dr. Almaraz at Johns Hopkins Hospital. Approximately 1 year after the operation, which was apparently successful, Dr. Almaraz died of AIDS. The Hospital attempted to contact each patient upon whom Dr. Almaraz operated, to notify him or her of the fact that Dr. Almaraz had died of AIDS, and to offer each a free test for the HIV virus. Mrs. Rossi took the test and was shown to be negative. Neverthe-

less, she sued for the emotional and psychological trauma caused by the fear of having contracted an HIV infection from Dr. Almaraz. Her suit is based on the theory that she had the right, before giving her consent to the operation, to be informed of the fact that Dr. Almaraz was HIV positive so that she could make an informed decision whether or not to permit Dr. Almaraz to proceed with the operation. I am advised that two other similar suits have now been filed in Baltimore.

This fact is also clear from a recent article, *Physicians and Acquired Immunodeficiency Syndrome*, published in the *Journal of the American Medical Association* in 1989.⁹⁵ That article reports on a survey of 2,000 persons interviewed throughout the United States. That report shows that 45% of those interviewed were of the opinion that a physician who was HIV positive should not be allowed to continue practice, and that 55.7% of those interviewed would switch physicians if they knew that their physicians were HIV-infected. Of those interviewed, 79.7% stated that an HIV-infected physician should notify his or her patients of that fact. Another 8.2% opined that this notification should be given if the patient asks. Only 7.9% were of the opinion that a physician need not inform his or her patient, even if asked.

This survey confirms a 1987 Gallup Poll, which found that 86% of those questioned opined that patients should be told if their physicians were HIV positive.⁹⁶ And these surveys were undertaken *before* there was knowledge, now widespread in the press, that one, and possibly five, patients probably have been infected with HIV by an HIV positive dentist in Florida.

As has been developed above, in Maryland, as now in about half of the states and the District of Columbia, the standard of the duty that a practitioner has to inform a patient before that patient gives his or her consent to a procedure or therapy is what the "reasonably prudent patient" would need to know to make an intelligent and informed decision. While, in our system, it is a judge who instructs a jury on the law, it must be kept in mind that it is a jury of laypersons who will ultimately decide whether the patient has been told enough to exercise his right of self-determination in whether and how his body should be treated.⁹⁷

III. Otherwise Qualified: Reasonable Accommodation

As was developed above, the right of an individual with a handicap to be treated equally to other persons depends upon whether that individual is "otherwise qualified," and generally there is a requirement that "reasonable accommodation" be made so that, as far as is possible, that individual can enjoy all of the benefits enjoyed by others. These requirements are differently stated in the 1973 Rehabilitation Act, in the 1990 Americans with Disabilities Act, in the Mary-

land statute, in the Howard County ordinance, and in the regulations implementing those various statutes; but by and large the requirement of each is quite similar.

Any development of this requirement must start with the Supreme Court's decision in *School Board of Nassau County v. Arline*.⁹⁸ There, the Court made clear the statutory "goal of protecting handicapped individuals from deprivations based on prejudice, stereotypes, or unfounded fear, while giving appropriate weight to such legitimate concerns . . . as avoiding exposing others to significant health and safety risks . . ."⁹⁹

Applying the Court's four-part analysis (see above, p. 31, text at n. 29) to assess whether "a person handicapped with a contagious disease" is prevented by that disease from being "otherwise qualified" to the case of an acupuncture practitioner or clinician, we find the following:

(a) The Nature of the Risk (How the Disease is Transmitted). There is little or no doubt today that an HIV infection is transmitted by the blood or semen of an infected person directly mixing with blood or semen of another or passing perinatally from an infected mother to her fetus. Thus, if a health care practitioner is HIV positive, for the disease to be transmitted from him or her to a patient, his or her blood or semen must enter directly into an opening of the patient and contact directly the patient's blood or mucosal membrane.

(b) The Duration of the Risk (How Long is the Carrier Infectious). By every bit of evidence available today, once a person is infected, he or she remains a carrier for life.

(c) The Severity of the Risk (What is the Potential Harm to Third Parties). Based upon current knowledge and technology, death is to be expected in every case.

(d) The Probabilities the Disease Will Be Transmitted and Will Cause Varying Degrees of Harm. Assuming that universal precautions are taken, the risk of transmittal from the practitioner or clinician to the patient is as close to nonexistent as one can imagine. This statement needs some development.

The law does not say that for an individual to be "otherwise qualified" there must be *no* risk at all. Rather, the risk that would permit a decision that an individual is not "otherwise qualified" must be a "significant risk." The Supreme Court in *Arline* made it clear that the goal of the 1973 Rehabilitation Act is to "protect[] handicapped individuals from deprivations based on prejudice, stereotypes, or unfounded fear, while giving appropriate weight to such legitimate concerns as avoiding exposing others to *significant health and safety risks*."¹⁰⁰ The Court went on:

A person who poses a *significant risk* of communicating an infectious disease to others in the

workplace will not be otherwise qualified for his or her job if reasonable accommodation will not eliminate that risk.¹⁰¹

The lower courts have ruled that a remote risk of acquiring AIDS is not sufficient to justify discrimination.¹⁰²

The standard of "significant risk" under the current law is not altered under the new Americans with Disabilities Act. Indeed, the legislative history of the ADA reflects the intent of Congress that the "significant risk" standard not be watered down in its application or interpretation. Indeed, it is clear that the intent of Congress is that "speculative or remote risk" or "merely elevated risk" is not to be considered "significant risk" and does not justify discrimination.¹⁰³

First, it should be recognized that scientific evaluation of the evidence available concerning the HIV has established

only transmission by blood, semen, and vaginal secretions. Whether transmission occurs may depend upon the concentration of virus in the fluid. People have been severely bitten by AIDS patients and still not contracted the disease. Mouth-to-mouth resuscitation also has failed to cause transmission. Studies of persons living with AIDS patients have shown that causal interaction does not transmit the disease. Sexual activity, intravenous drug use, and birthing may transmit the HIV virus . . . [T]he blood of the doctor or student must spill in an operative site, area of inflammation or open wound to create *any* risk of spreading HIV to the patient.¹⁰⁴

Turning now to the college and its adjunct clinic, it is clear that disposable needles are used, except in unusual instances (and then never by students without at hand supervision), in which case the needles are sterilized in an autoclave before reuse. There is no doubt that the autoclave, used properly, sterilizes needles well enough to remove the AIDS virus along with other viruses and bacteria that can result in infection. The clinic and college do not permit a needle to be used on more than one person, and the students are so instructed. Thus, should a student or practitioner inadvertently stab him or herself with a needle, that needle, if disposable, should immediately be put into the container for disposal, and, if not disposable, should immediately be put into the container for sterilization in an autoclave.

Moreover, if a practitioner or clinician has any open lesions or weeping dermatitis, generally accepted precautions require that those lesions be covered completely by a bandage or bandaid, and if that is not possible, that the practitioner or clinician refrain from direct patient contact until the condition of the practitioner or clinician improves to the point where there are no open lesions or weeping dermatitis that cannot be completely contained by bandaging. This prevents any blood or other bodily fluid from leaving the prac-

itioner or clinician and entering into a patient through some opening in the patient's skin.

With these universal precautions, the chance of transmission of the HIV—or the hepatitis B virus, which is transmitted similarly and, by all indications, more easily—from the practitioner or the clinician to the patient is practically nonexistent.

The only possibility of transmission from practitioner to the patient is the situation in which the infected practitioner pricks himself with the needle without being aware of that fact, drawing his or her own blood, which either then remains on the needle when it is inserted into the patient or dribbles onto the patient at a point of an open lesion, perhaps the lesion caused earlier by the insertion of an acupuncture needle. From my inquiries, I am quite certain that this is not within the realm of the possible in the situation posed: there is no way that there would not be feeling in the practitioner should a needle prick to such a distance under the skin as to draw blood. Moreover, scientific inquiry has established that "a small inoculum of contaminated blood is unlikely to transmit the virus."¹⁰⁵

Indeed, survey after survey has shown that the risk of transmission in a much more dangerous situation than is posed by acupuncture is extremely small. A surgeon, or a dentist, has his or her fingers or hands in an open cavity of the patient, with the patient's blood flowing and with the immediate presence of sharp instruments on which the surgeon or dentist may cut him or herself, thus releasing the practitioner's blood to mingle with the blood of the patient. Surgeons have advised this author that cuts and nicks in surgical gloves are to be expected during any extensive operation. Indeed, one neurosurgeon advised this author that he expects to have his gloves cut, and need replacement, on the average of once every half hour to an hour, and that about a third of the time the cut goes through the glove to his skin. Professor Gostin cited studies that indicate "a surgeon will cut a glove in approximately one out of every four cases, and probably sustain a significant skin cut in one of every forty cases."¹⁰⁶

There have been several cases reported of HIV positive surgeons and dentists. On several occasions, surveys and tests have been conducted of the former patients of those surgeons and dentists. Surveys and tests of literally thousands of such patients have now been made. The result is that in only one instance has transmission of HIV infection from a single dentist to a patient been confirmed as a probability, with four other cases of transmission from the same dentist suspected. Even those cases are disputed by qualified scientists, who say that the evidence is far from clear.¹⁰⁷

The difference between the surgeon and the dentist on the one hand and the acupuncturist on the other is profound: while the surgeon or the dentist has his or her fingers or hand inside a patient's cavity, where there are sharp instruments on which the sur-

geon or dentist can be cut, permitting the blood of the surgeon or dentist to mingle with that of the patient, that is just not true with an acupuncturist. The acupuncturist does not practice inside a cavity of a patient. Nor are there sharp instruments on which the acupuncturist can cut him or herself and spread blood from the acupuncturist to mingle with blood of the patient. The acupuncturist should not puncture himself. But if he or she should do so accidentally, the acupuncturist is not situated over an open, bleeding cavity of the patient. And, of course, using generally accepted precautions, the acupuncturist should not use on the patient a needle that accidentally or otherwise punctured the acupuncturist or anyone else.

Thus, to return to the *Arline* analysis: there is no risk of transmission from the acupuncturist or the clinician to the patient. Any risk is, at best, remote and speculative. Clearly, it does not rise to the "significant risk" standard of the law.

This should end the analysis, for it would appear that federal, state, and county laws would, in this instance, ensure that the HIV positive practitioner or student is treated by an employer or a school in the same manner as any other practitioner or student is treated—except for the apparent conflict with the right of the prudent patient to be informed of such risks as he or she needs in order to make an intelligent and informed decision, and the evidence that indicates that most people feel that they should be informed if their physicians are HIV positive.

There is one other factor as well. At least the Americans with Disabilities Act contains a qualification that an employer or a school is to make such modifications of criteria, procedures, practices, etc., to reasonably accommodate a handicapped individual unless such modification "would fundamentally alter the nature of the goods, services, facilities, privileges, advantages, or accommodations" offered by the employer or the school.¹⁰⁸

One must approach this "straw" with caution, however. It is a qualification on the statutory duty to modify already existing procedures, practices, etc., when there is already an "otherwise qualified" handicapped individual and such a modification is necessary to reasonably accommodate that person's handicap. It is not framed as an authorization to discriminate against the handicapped individual in order to prevent a "fundamental[] alter[ation of] the nature of the goods, services, facilities, privileges, advantages, or accommodations" offered by the employer or the school.

Nevertheless, it constitutes a recognition that the employer or the school furnishes certain goods, services, etc., and it is asking too much that they should be fundamentally altered in order to provide for a handicapped person. Moreover, it is a reminder that the "otherwise qualified" requirement contemplates that there will be people who, because of their handicaps, are not qualified.¹⁰⁹

An easy, although absurd example is that of the

quadriplegic who insists on being hired for the professional football or basketball team. In *Southeastern Community College*,¹¹⁰ the Supreme Court ruled that a college could conclude that a hearing-impaired person was not "otherwise qualified" to participate in a nursing school program because of safety factors. The Federal Court of Appeals for the Seventh Circuit ruled that a law school did not violate the Rehabilitation Law by expelling a student who suffered from alcohol addiction after the school gave the student two chances at rehabilitation.¹¹¹ The Second Circuit ruled that a medical school could exclude a mentally ill student because of concerns for safety.¹¹² And the Sixth Circuit permitted a school of optometry to discriminate against an individual who had insufficient dexterity to perform delicate procedures required in the program.¹¹³

Putting the matter into an acupuncture setting, it could hardly be contended that an acupuncture school would violate the Rehabilitation Act by failing to admit an individual who has Parkinson's or some other disease of palsy that prevents the individual from holding his or her hand steady, permitting the insertion of the needle at the point intended. Another example is that of a person with impaired mental or psychomotor skills, resulting from AIDS, so that diagnostic or treatment techniques were inhibited.¹¹⁴ Nor would it violate either the Rehabilitation Act or the ADA to refuse to graduate such a person if the condition or the severity thereof manifested itself after matriculation, or, if the condition were apparent upon admission, should attempts at reasonable accommodation have failed.

This factor begs the next question: what is it about the fact that the college is a school of higher education, and particularly an acupuncture school, that should be considered in the equation. Particular focus should be given to the essential philosophical basis of traditional acupuncture that each person is responsible for his or her body, mind, and spirit, to keep each of those well and in balance, and to remedy for him or herself any imbalance or disease that may occur, with the practitioner being only a helper along the way. This, of course, brings into the same focus the "prudent patient" concepts of the Maryland informed consent requirement.

IV. Academic Freedom

If we were dealing solely with a practitioner who was faced with hiring a young associate, the issue would be difficult but still only between the statutory restrictions on discrimination against the handicapped, on the one hand, and the right of a patient to be fully informed in giving his or her consent to a procedure or therapy that involves his or her body. But here we have a third factor to consider: the academy. The college is a school of higher education, authorized by the state to bestow a Master's degree.

And the academy has certain freedom and rights recognized within our law. Justice Felix Frankfurter, in a pivotal Supreme Court concurrence, presented

four essential freedoms of the university—to determine for itself on academic grounds who may teach, what may be taught, how it shall be taught, and who may be admitted to study.¹¹⁵

While the concept of academic freedom originated in a struggle for the freedom of faculty members against administrators and lay boards,¹¹⁶ it has emerged as a constitutional doctrine as the freedom of the academy against governmental interference. The constitutional doctrine of academic freedom was born in the McCarthy era, when the courts on many occasions stood as bulwarks against governmental attempts to weed out of the universities persons with views that were then unpopular.

The story begins with *Sweezy v. New Hampshire*. Professor Sweezy was found in contempt for failure to answer questions concerning the content of his teaching posed by the New Hampshire Attorney General in a McCarthy-type inquisition.

The plurality opinion, written by Chief Justice Warren, reversed on grounds other than academic freedom. Chief Justice Warren noted that academic freedom was a consideration in the case, stating, "The essentiality of freedom in the community of American universities is almost self-evident." He went on to declare: "We do not now conceive of any circumstance wherein a state interest would justify infringement of rights in these fields."¹¹⁷

In his concurrence, Justice Frankfurter spoke of "the dependence of a free society on free universities. This means the exclusion of governmental intervention in the intellectual life of a university."¹¹⁸

The Court returned to this theme 10 years later when, in *Kayishian v. Board of Regents*,¹¹⁹ it struck down a New York McCarthy-era law designed to ferret out hidden "subversives" from New York universities. Justice Brennan, speaking for the Court, declared:

Our Nation is deeply committed to safeguarding academic freedom, which is of transcendent value to all of us and not merely to the teachers concerned. That freedom is therefore a special concern of the First Amendment, which does not tolerate laws that cast a pall of orthodoxy over the classroom. "The vigilant protection of constitutional freedoms is nowhere more vital than in the community of American schools." The classroom is peculiarly the "marketplace of ideas." The Nation's future depends upon leaders trained through wide exposure to that robust exchange of ideas which discovers truth "out of a multitude of tongues, [rather] than through any kind of authoritative selection."¹²⁰

With this as seminal constitutional doctrine, the Court has gone on to give some content to the freedom of the academy that is directly pertinent to our prob-

lem. In his controlling opinion in *Regents of California v. Bakke*,¹²¹ Justice Powell recognized that the Fourteenth Amendment and the Civil Rights Act prohibited any state instrumentality from penalizing any applicant because of his race. But, relying on Justice Frankfurter's "four essential freedoms of the University,"¹²² Justice Powell concluded that the First Amendment right of academic freedom empowers a state university to take race or national origin into account in admitting students when doing so in pursuit of the academic goal of a diverse student body.¹²³ "The atmosphere of 'speculation, experimentation and creation'—so essential to the quality of higher education—is widely believed to be promoted by a diverse student body."¹²⁴ Thus, the academy was given the right to consider race or national origin—as an element of academic freedom—when other segments of society were more tightly bound not to discriminate.

In two cases, the Supreme Court applied these principles to situations in which universities dismissed students. Both involved medical students and judgments made by the faculty that the students should not continue. In one, *Board of Curators, Univ. of Missouri v. Horowitz*,¹²⁵ the student was not permitted to graduate and was dismissed on an evaluation of her clinical performance, including her ability to relate with patients, her personal hygiene, and her erratic attendance. In the other, *Regents of Univ. of Michigan v. Ewing*,¹²⁶ a student had failed a significant examination, which the student was not allowed to retake, even though all other students who had failed that examination in the immediate preceding years had been allowed to retake it, some two and even three times. The trial court had found that Ewing had been having academic difficulty since he began the program, failing other courses, and in other ways had a very poor record. Both Horowitz and Ewing went to court, claiming a constitutional liberty and property right in continuing in her and his education and that the university had deprived each of that right without due process. In each case, the court of appeals had ruled for the student and the Supreme Court reversed.

Significant to our discussion is that the Supreme Court specifically referred to "a reluctance to trench on the prerogatives of state and local educational institutions and our responsibility to safeguard their academic freedom, 'a special concern of the First Amendment.'"¹²⁷ The Court went on:

Academic freedom thrives not only on the independent and uninhibited exchange of ideas among teachers and students,[128] . . . but also, and somewhat inconsistently, on autonomous decisionmaking by the academy itself.[129] . . . Discretion to determine, on academic grounds, who may be admitted to study, has been described as one of "the four essential freedoms" of a university.¹³⁰

Thus, "when judges are asked to review the substance of a genuinely academic decision, such as this

one, they should show great respect for the faculty's professional judgment. Plainly, they may not override it unless it is such a substantial departure from accepted academic norms as to demonstrate that the person or committee responsible did not actually exercise academic judgment."¹³¹ "University faculties must have the widest range of discretion in making judgments as to the academic performance of students and their entitlement to promotion or graduation."¹³²

This principle was recently reaffirmed by the Supreme Court in *University of Pennsylvania v. Equal Employment Opportunity Commission*.¹³³

[C]ourts have stressed the importance of avoiding second-guessing of legitimate academic judgments. This Court itself has cautioned that "judges . . . asked to review the substance of a genuinely academic decision . . . should show great respect for the faculty's professional judgment." [134] . . . Nothing we say today should be understood as a retreat from this principle of respect for *legitimate* academic decisionmaking.

This, of course, does not mean that everything the academy does is free from government interference. In *University of Pennsylvania v. EEOC*, for example, the Court rejected the university's argument that academic freedom prohibited the EEOC from requiring the university to turn over tenure files, including copies of otherwise confidential evaluations and notes of deliberations, in an investigation concerning discrimination in tenuring. Nor is the academy free from barring meetings of student religious groups, when the campus is open to meetings of other groups,¹³⁵ or of a student group on the ground that its political views are unpalatable to the state college.¹³⁶ Nor will freedom of the academy protect a faculty member from having to testify about subversive activities among graduate students at the university, the court stating that a university is not a "constitutional sanctuary from inquiry into matters that may otherwise be within the constitutional legislative domain . . ."¹³⁷

Thus, it is clear that the academy may not refuse to admit blacks, females, Jews, Catholics, Hispanics, etc., as students. Nor may the academy refuse to hire such persons or, once hired, to grant them tenure. But a decision of whether a particular person should be hired or tenured, or whether a particular person should be admitted as a student, dismissed on academic grounds, or permitted to graduate, comes within the freedom of the academy as long as the decision is made upon legitimate academic grounds.

Another area that we may assume is protected by academic freedom is the qualifications for graduation. The state, of course, may lay down a minimum hour requirement for the award of a certain degree. But what the school wishes to produce in the form of a lawyer or a botanist or a nurse or a physician, and whether a particular person meets that requirement, is up to the academic judgment of the academy. Thus, a court would not review whether the University of

Missouri was correct or incorrect in refusing to graduate Ms. Horowitz on the ground that she lacked the necessary clinical skills of a physician. The University of Michigan's decision not to allow Mr. Ewing to retake an exam but, instead, to dismiss him from the program because, in the judgment of the faculty, his accumulated record warranted such dismissal, is an academic judgment not to be reviewed by a court.

Turning now to the field of acupuncture education, it appears from these cases that the academy has the freedom to determine what makes a good acupuncturist. If the academy decides that a very important ingredient is the rapport, the trust between the practitioner and the patient, the academy is free to make the academic decision whether a particular student has the ability and the willingness to create that rapport and that trust.

Thus, the academy can develop its own view of what a competent acupuncture practitioner should be, including all aspects of clinical demeanor and practitioner-patient relationship. Also, the academy may decide, on sound academic analysis, that a particular person, for whatever sound academic reason, including his or her demeanor, hygienic appearance, bedside manner, respect for others, understanding of universal safety precautions, and willingness to follow them, etc., is not capable of being a qualified acupuncturist no matter how high he or she may score on examinations in didactic courses. This is a part of that freedom of the academy first presented in *Sweezy* and *Kayishian* and then applied to somewhat analogous situations in *Horowitz* and *Ewing*.

Of course, as a practical matter, the academy is not entirely free from the influence of the state and others. As the state licenses professionals, it may decide that, for an individual to be licensed, certain courses must be taken during his or her education. While that is not a directive to the academy of what to teach, the failure to teach that which qualifies graduates for licensure will reduce the willingness of students to attend that particular academy. The same influence is exerted by accrediting bodies. But the choice still remains with the academy of what and how to teach within those requirements, and, of course, the academy may always require more than is required by the state or by accrediting standards.

V. Analysis and Conclusion

A. Values in Conflict

There are three basic values in conflict in the situation presented:

1. There is a strong public policy, expressed at all levels of government, that the handicapped not be discriminated against just because of his or her handicap, unless that handicap truly disables the person from doing the task at hand, and even then only if reasonable accommodation will not solve the problem posed by the handicap; no em-

ployer and no place of public accommodation should act in accordance with irrational prejudice toward the handicapped.

2. There is the right of the patient to control what happens to his or her own body, expressed as the right of a patient who is not an infant, incompetent, or unconscious, to have a health care procedure done to his or her body or a therapy undertaken only with his or her consent; the health care practitioner has the duty to inform the patient fully of any significant risk of which the patient needs to know in order to make an intelligent and informed decision.

3. The academy has the freedom to decide, on sound academic grounds, who should be admitted to study, what he or she should be taught from all aspects of the discipline, and who is qualified to be promoted and eventually to graduate.

The conflict concerning the handicapped and the patient may be expressed as follows: the law prohibits the employer and the entity that offers public accommodation to discriminate without rational reason, and even then only where reasonable accommodation is not possible. But the customer is permitted to discriminate, no matter how irrationally. Thus, while the retail establishment cannot keep out a customer because he or she is black, Hispanic, oriental, Jewish, or Baptist, or is in a wheelchair, the customer can decide to avoid any retail establishment that is owned by, or employs, a black, an hispanic, an oriental, a Jew, a Baptist, or a person in a wheelchair. Likewise, while a school cannot refuse admission to someone because he is black, hispanic, oriental, Jewish, or Baptist, the black student can decide to go only to a black school; the Jew can decide to go only to a Jewish school; and the Baptist can decide to go only to a Baptist school.

The same is true, of course, in the health care business: a health care professional cannot refuse to serve someone because he is black or oriental or Jewish or Baptist or female. But the patient can choose not to patronize (or to go only to) a black or oriental or Jewish or Baptist or female practitioner.

Putting this analysis in terms of HIV positivity: an employer cannot refuse to employ (and cannot fire) an employee who is HIV positive who is "otherwise qualified." That is true of a health care practitioner who employs others. But a patient can refuse to be treated in the office or clinic of a health care practitioner who employs anyone who is HIV positive, whether or not he or she is "otherwise qualified." Thus, a patient may ask of his or her practitioner: are you HIV positive? If the answer is yes, or if the practitioner refuses to answer the question, the patient has the right not to consent to the treatment—no matter how irrationally the patient is acting, for there is no law that permits a patient, as a customer, to discriminate against a person handicapped by HIV infection only for rational reasons.

B. The Policy of Others

This issue, of course, is not exclusive to acupuncture. It is one with which both the medical and the dental professions have been grappling. The Centers for Disease Control in 1987 issued the following guideline:

The question of whether workers infected with HIV—especially those who perform invasive procedures—can adequately and safely be allowed to perform patient care duties or whether their work assignments should be changed must be determined on an individual basis. These decisions should be made by the health care worker's personal physician(s) in conjunction with the medical directors and personnel health service staff of the employing institution or hospital.¹³⁸

The CDC defined the term "invasive procedure" rather strictly, as

surgical entry into tissues, cavities, or organs or repair of major traumatic injuries (1) in an operating or delivery room, emergency department, or outpatient setting, including both physicians' and dentists' offices; (2) cardiac catheterization and angiographic procedures; (3) a vaginal or cesarean delivery or other invasive obstetric procedure during which bleeding may occur; or (4) the manipulation, cutting, or removal of any oral or perioral tissues, including tooth structure, during which bleeding occurs or the potential for bleeding exists.¹³⁹

The Council on Ethical and Judicial Affairs of the American Medical Association in 1988 issued an opinion that:

A physician who knows that he or she has an infectious disease should not engage in any activity that creates a risk of transmission of the disease to others

The Council . . . reiterates and reaffirms the AMA's strong belief that AIDS victims and those who are seropositive should not be treated unfairly or suffer from discrimination. However, in the special context of the provision of medical care, the Council believes that, if a risk of transmission of an infectious disease from a physician to a patient exists, disclosure of that risk to patients is not enough; patients are entitled to expect that their physicians will not increase their exposure to the risk of contracting an infectious disease, even minimally. If no risk does exist, disclosure of the physician's medical condition to his or her patients will serve no rational purpose; if a risk does exist, the physician should not engage in the activity There may be an occasion when a patient who is fully informed of the physician's condition and the risks that condition presents may choose to continue his or her care with the seropositive physician. Great care must be exer-

cised to ensure that true informed consent is obtained.¹⁴⁰

The American Medical Association itself, in January 1991, after the Centers for Disease Control announced that there was strong evidence that HIV infection had been transmitted from a dentist to one and possibly five patients, issued a strong statement:

The health of patients must always be the paramount concern of physicians. Consequently, until the uncertainty about transmission is resolved, the American Medical Association believes that HIV infected physicians should either abstain from performing invasive procedures which pose an identifiable risk of transmission or disclose their sero-positive status prior to performing a procedure and proceed only if there is informed consent.¹⁴¹

The American Dental Association issued a similar statement on January 16, 1991:

Currently, there is no scientific evidence to indicate that HIV-positive healthcare providers pose an identifiable risk of HIV transmission to their patients. There has been only one documented case of transmission from an HIV infected health care provider to patients during the past ten years of experience with AIDS, an indication that the risk is infinitesimal. The ADA continues to believe that the recommended infection control procedures are effective in preventing transmission of infection.

However, the recent case of possible HIV transmission from dentist to patient has raised some uncertainty about the risk of transmission from healthcare provider to patient. While there is evidence that this dental practice did not consistently adhere to all recommended guidelines for prevention of disease transmission, the precise mechanism of transmission in this case remains unknown. This uncertainty leads to the conclusion that the foremost concern of the dental profession must continue to be protection of the patient. Thus, unless the uncertainty about transmission is resolved, the ADA believes that HIV-infected dentists should refrain from performing invasive procedures or should disclose their seropositive status.

The New York State Department of Health also issued a policy and guidelines statement in January 1991. The New York statement emphasized that, based on "all available data," the "risk of HIV transmission from infected health care personnel to their patients" is "extremely low"; the "risk can be described as remote but cannot be quantified precisely." The department's conclusion is "that HIV-infected professionals should continue all professional practice for which they are qualified, with rigorous adherence to

universal precautions and scientifically accepted infection control practices.”

As a general principle, limiting the practice of HIV-infected health care professionals is not necessary or justified unless there is clear evidence that such workers pose a significant risk of transmitting infection through an inability to meet basic infection control standards or unless they are functionally unable to care for patients.

The department emphasized the importance of adhering to universal barrier techniques to protect both the health worker and the patient.

The American Association of Medical Colleges has declared that its institutions may legitimately modify the clinical activities of students and faculty because of the “conceivable” risk that transfer of disease may occur during invasive procedures, but makes no recommendation that they do so.¹⁴² The American Association of Dental Schools recommends that HIV-infected dentists and students should not engage in activities that create a risk of transmitting HIV to a patient, but does not recommend restrictions on HIV positive faculty or students.¹⁴³

Largely through the National Association of University and College Attorneys, I have obtained the statements of four universities. No representation is made that these statements are inclusive of all that have been adopted by various universities, or that they are even representative, only that these were all that were obtained. As these statements are designed to guide the conduct of both practitioners and students at teaching health care facilities, they are instructive of what these institutions have done.

1. Georgetown University. Based upon the 1987 CDC guidelines, Georgetown’s policy is that HIV-infected health care personnel continue to be employed, with a case by case determination to be made concerning each infected employee. However, no HIV-infected practitioner, employee, or student is to perform “invasive procedures unless such activity is approved by a committee consisting of the person’s own physician, the Hospital Medical Director and the Employee Health Service Medical Director.”¹⁴⁴

2. Howard University. No health care worker or student who has oozing lesions or weeping dermatitis, regardless of infection with AIDS, is allowed to have direct contact with patients until the condition clears. Health care workers and students who are HIV-infected and who do not perform invasive procedures are not restricted unless some other condition requires such restriction. The work assignment of such a person is considered on an individual basis upon an assessment of health and safety risks to patients and to the worker or student.¹⁴⁵

3. University of West Virginia. HIV-infected health care workers and students “must not engage in any activity that creates a risk of transmission of HIV infection to others, such as invasive procedures.”

Workers or students “who are not involved in direct patient care or do not perform invasive procedures do not pose a risk to patients and should not be restricted in their activity unless they have other transmissible infection/s . . .” (Emphasis added.) Any modification of the clinical training or privileges of HIV-infected medical students or staff is determined on a case by case basis, “taking into account the nature of the clinical activity, the technical expertise of the infected person, and the risks posed by HIV carriage, attendant functional disabilities, and the transmissibility of simultaneously carried infectious agents.”¹⁴⁶

4. University of North Dakota. There is a Significant Infectious Disease Committee, and any employee or student who is diagnosed with AIDS may, if he or she wishes, request from this committee “reasonable accommodation for or workplace restrictions on a faculty or staff member . . . [or] reasonable accommodations or restrictions on the educational programs or other University activities of a student diagnosed as having AIDS.”¹⁴⁷

C. Resolution

Once again, it must be recalled that it is the academy with which we are concerned. Thus, whatever policy is arrived at should be based primarily upon the teaching and training mission of the academy. This policy should be arrived at by a weighing of all of those academic concerns of this particular academy.

In this case, the college is educating and training practitioners of traditional acupuncture. The end product sought is a practitioner who is successful with patients in the mode that is traditional acupuncture. This mode is more than the mechanical taking of pulses and insertion of needles. There is a direct and personal relationship between practitioner and patient that goes beyond, and indeed makes meaningful, the diagnostic techniques and the needling that follows. The college is entitled to make, and, indeed, has the responsibility to make, the considered academic judgment as to what is a practitioner of traditional acupuncture, that is, what is the product that the college aims to produce. The college may sketch out those elements that, in its considered academic judgment, goes to make up such an individual. The college may also decide, upon sound and rational academic grounds, whether a particular individual possesses those qualifications that, in its judgment, would make him or her a good bet to benefit from the education and training offered by the college and would probably emerge as the practitioner that the college desired to produce.

Similarly, the college, at every step of the way through the educational and training process, may make the rational academic judgment whether an individual student has those necessary qualifications to move on to the next step. When a student, in the sound academic judgment of the college, does not possess those qualifications, the college may decide, and indeed has the responsibility to decide, not to

permit that student to move forward, even if that means dropping from the program.

Finally, the college has the duty to make the rational academic judgment whether a student who

The college is entitled to make, and, indeed, has the responsibility to make, the considered academic judgment as to what is a practitioner of traditional acupuncture.

has come to the completion of the program offered by the college has emerged with the skills, maturity, and ability which the college has identified as the practitioner that it is its aim to produce. And when, in the sound academic judgment of the college, a student does not measure up to that standard, the college may determine that that student is not qualified to receive its degree and to be sent into the world with its imprimatur.

Thus, in the final analysis, what goes into a qualified student for the purpose of admission, promotion, and graduation is the responsibility of the college. And, as long as those decisions are made upon sound academic grounds, courts will not second guess.

That, of course, does not mean that a school may decide that no black or no Hispanic or no Jew or no Baptist could emerge as that school's qualified product. The qualification must be rationally related to the end result, which, in this case, is an acupuncture practitioner. There must be some rational connection between the perceived lack of qualification of the individual student and the end result sought. Thus, it would seem to me, an acupuncture school could decide that sensitivity of fingers of pulses and steadiness of hand with needling are essential qualifications of an acupuncturist, and an individual who lacks those abilities could rationally be denied admission, refused promotion, or restricted from graduation.

Likewise, it is up to the college to decide how much of a rapport between patient and practitioner plays in a successful practitioner. Thus, the college may determine that, within its vision of a successful practitioner of acupuncture, what may be called "bedside manner" is of a certain significance for both diagnostic and treatment purposes. The college may decide what factors it believes goes into the proper "bedside manner" of a successful practitioner: perhaps such items as trust, confidence, empathetic listening, tactful questioning, and communication skills. The college could then put these factors into its qualifications for admission, promotion, and graduation, as well as into its curriculum. Just as the University of Missouri could decide in *Horowitz* that the student's clinical manner just did not measure up to what the university expected of its graduate product,

the college could decide, upon sound academic grounds, that a particular person should not be admitted, promoted, or graduated because he or she did not possess enough of those qualities of rapport to be the kind of practitioner that the college would wish to send out into the world with its imprimatur.

In short, it is the college that has the freedom and that bears the responsibility—as the Academy—of deciding what its teaching shall be and what product it wishes to produce in the form of practitioners. And it is the college, as the academy, that has the freedom and the responsibility of deciding for each student whether he or she measures up to the college's image in order to be promoted and ultimately graduated. As long as those decisions are made on sound academic grounds in terms of the mission of the college, current law would uphold the judgment of the college.

In making these decisions, the college must consider the impact on it of the various statutes that prohibit discrimination against the individuals with handicaps who are "otherwise qualified." Upon my inquiries, I have concluded that the current federal Rehabilitation Act applies to the college. I have been advised that some federal medicare and/or medicaid money has been received. It is unclear whether that was received by the Acupuncture Center or by the college, but I expect that it makes no difference. The two entities, while separate corporations, work together so closely and are so intertwined that it is my opinion that they will probably be treated as one for the purposes of the Rehabilitation Act. As that Act was amended by the Civil Rights Restoration Act of 1988, if any one part of an entity receives federal funds, all parts of the entity are covered by the Rehabilitation Act and other federal civil rights acts. There is, of course, no doubt that the college will be covered under the new Americans with Disabilities Act as of January 1992.

On the state level, the picture is not as clear. If the college, as a school, is considered solely as a public accommodation, it comes within the Maryland legislation only if it is licensed or regulated by the Maryland Department of Licensing and Regulation. I am advised by officials of the college that they are aware of no licensing or regulation by the Department of Licensing and Regulation, but that the college is approved and regulated solely by the Board of Higher Education. Assuming the accuracy of that fact, the Maryland statute does not apply—as far as the college is to be considered a public accommodation. But, as far as the college is an employer, it is covered by the state act. And it is at least arguable that a clinician, who earns fees for the college, is to be considered an employee for at least some purposes. As the matter is not clear, it cannot be stated with certainty that the state act has no application to the college.

On the other hand, the Howard County ordinance is written broadly enough that I expect there will be little trouble in applying it to the college.

Whatever application the statutory commands may have in making these decisions in terms of persons who are handicapped, by HIV infection or otherwise, I urge that the college take into serious consideration the national public policy to do away with irrational prejudices and stereotyping of those who are handicapped. Thus, I urge that very serious consideration be given to whether a person who is handicapped is "otherwise qualified" to be a traditional acupuncturist or whether his or her handicap stands in the way of that individual becoming a successful acupuncturist within the college's vision of such a person. If the college, in its sound academic judgment, believes that the individual is not qualified because of his or her handicap, then I urge that the college consider every possibility of a reasonable accommodation that would make that individual qualified: perhaps extra help, extra supervision, or extra barrier protection. Only if the college, upon sound academic grounds, concludes that no reasonable accommodation can be made without destroying the vision or the standards of the college, or without expense unreasonable for the college to bear, should the college further conclude that that student should not be promoted or graduated.

Furthermore, I urge that the college consider maximum protection of the patient from infection and ensure that every step possible be taken to prevent the spread of infection from the practitioner or clinician to the patient. Thus, every element of the universal precautions, and other precautions that appear to be appropriate to the college's particular situation, should be taken. These elements should be clearly spelled out in the teaching of the college and in the handbooks for both practitioner and clinician. They should be looked for by all supervisors, and considered in all evaluations. If, in the considered academic judgment of the college, some further precautions should be developed and instituted for one or more particular practitioners or clinicians in order to make a reasonable accommodation of any handicap that such persons may have, they should be arrived at with a rational relation between the problem and the intended end result, and spelled out clearly to the persons involved.

Yet, the college may decide that a person who is HIV positive, and thus, may be subject to an attack of dementia as a first sign of passing over to full AIDS,¹⁴⁸ has a hepatitis B infection, is subject to epileptic fits, has a mental illness that causes sudden difficulties, or is a recovering alcoholic who at times is overtaken by his or her addiction, should have some enhanced level of supervision. Moreover, the college may decide that a student in this condition may need some additional or special instruction as to how to accommodate the handicap when he or she is out in practice. Both of these accommodations should be worked out with the practitioner or student in consultation with that person's physician.

Finally, the college should consider the interest that the patient, in giving his or her informed consent to the procedure of acupuncture being performed on his or her body, has in being fully advised of all risks of that procedure. In my opinion, that means all real risks, and not those that are imaginary or speculative or so remote as to approach zero chance of happening.

In making these decisions, the college, of course, must consider the law and, as much as possible, avoid situations in which it may become liable. But there really is no way to avoid the possibility of suit. As the college must make a decision in an area in which there are conflicting values and legal rights, one in which no one really has a definitive and "safe" answer, there is no way to be certain that someone who is disappointed by the decision reached may not wish to take this matter to court in order to establish a principle or remedy a perceived wrong. While, of course, the college must consider the impact of the law when it reaches its decision, I urge that the college decide what is right and what best carries out its vision of itself, of its mission, and of its responsibility to that mission.

While the decision of how to proceed is, and must be, that of the college, you have asked for my specific recommendations. I give them with the understanding that they are only recommendations; I do not presume to preempt the college's responsibility to make the final decisions. My recommendations are as follows:

1. Add to the general informed consent form of the college a provision recognizing that there are concerns about the spread of infectious disease, both through body fluids and through the air. Recognize that, in the nature of things, a practitioner or clinician from time to time may have an infection, known or unknown to that person. Then advise the patient in general of the precautions that are taken at the college (e.g., the use of disposable needles, the following of universal precautions established by the American scientific community, the following of clean needle techniques established by the National Certification Commission for Acupuncture, the precautions taken against transmission of airborne infections). Invite the patient who has any questions about these matters to inquire further of his or her individual practitioner.

2. Send a letter to all current patients, acknowledging the concern felt by some because of the cases of the Florida dentist and of the Baltimore surgeon. Recognize that, in the nature of things, a practitioner or clinician from time to time may have an infection, known or unknown to that person. Then advise the patient in general of the precautions that are taken at the college (e.g., the use of disposable needles, the following of universal precautions established by the American scientific community, the following of clean needle techniques established by the National

Certification Commission for Acupuncturists, the precautions taken against transmission of airborne infections). Invite the patient who has any questions about these matters to inquire further of his or her individual practitioner.

3. Review the practitioners' and the clinicians' handbook(s) to be sure that each spells out clearly the precautions to be taken, including, but not limited to: do not use a needle on more than one person; if you accidentally prick yourself with a needle, do not use that needle on the patient; if a needle accidentally falls on the floor or touches any other nonsterile surface, do not use it on anyone; do not go into a patient's room with any open sore, no matter how miniscule it is, or with any weeping dermatitis; if the open sore or dermatitis can be covered completely with a bandage or bandaid, do so; if not, do not proceed with the treatment; if a clinician has any open sore or dermatitis, he or she should call that matter to the attention of his or her supervisor before going into a patient's room, and the supervisor shall decide whether the sore or dermatitis is sufficiently covered and safe for the clinician to proceed into the room; if the practitioner or clinician is pricked by a needle that has already been used on a patient, he or she should immediately report that fact to his or her supervisor. These matters should also be taught and emphasized in the curriculum, and a student's ability and willingness to follow them should enter into his or her evaluation.

4. Place into the practitioners' and the clinicians' handbook, and include in the curriculum, that it is the duty of the practitioner and the clinician to be sure that the patient has read the informed consent form and understands it. The practitioner and clinician have the duty to explain any portions that appear to be less than fully understood and perhaps go over orally those portions of the form that the experience of the practitioner has shown are usually not fully understood or appreciated. Furthermore, the practitioner and clinician must be told to expect questions on infectious disease and other matters. Those questions may involve questions personal to the practitioner or clinician. The practitioner and clinician should be told that he or she should answer each question honestly to alleviate the concerns of the patient. Should a patient ask a personal question that the practitioner or clinician feels is inappropriate (i.e., seeking information that would not assist the patient in making the informed decision as to whether or not to proceed with the acupuncture therapy), the practitioner or clinician may refrain from answering, explaining fully to the patient why the practitioner or clinician has concluded that the question seeks to elicit information that, in the opinion of the practi-

tioner or clinician, is not material to the weighing of risks and the decision whether or not to permit this practitioner or clinician to proceed with the particular procedure. Above all, the practitioner or clinician should be instructed not to lie in answering any question.

5. Include in the practitioners' and clinicians' handbook a statement that, if a person has a handicap, whether a physical infirmity, a mental problem, or an infection, it should be reported to his or her supervisor for evaluation of whether the safety of the patient permits the practitioner or clinician to proceed, and that every effort will be made to institute reasonable precautions that will accommodate the handicap and permit the practitioner or clinician to proceed. Those precautions must be followed. Those precautions may include additional supervision, additional barrier precautions, additional techniques to be taught and practiced, and other precautions that would, as much as possible, accommodate the handicap.

6. There is no need for any practitioner or clinician to advise a patient or a prospective patient of a specific handicap or condition of the practitioner or clinician as a part of the informed consent procedure or otherwise. If the handicap or condition poses a danger to the patient, the particular practitioner or clinician shall not treat patients unless or until the handicap or condition is remedied (e.g., a flu condition passes) or a reasonable accommodation, if any is possible, is made. If the handicap or condition poses no danger to the patient, it is not material to the patient's decision whether to proceed.

7. As the specific question here concerns who is HIV positive, when I apply these principles to this question I recommend as follows: the general informed consent form should be amended as recommended above; it should be explained by the practitioner or clinician; the practitioner or clinician should be ready to answer any material question, refrain from answering those questions that the practitioner or clinician feels are not material, stating why it is not material, but shall not lie; in my judgment, whether a practitioner or clinician is HIV positive is not material to the patient's decision whether to proceed with the acupuncture therapy, because it furnishes no appreciable risk to the patient. Moreover, in consultation with the student's physician, consideration should be given to enhanced supervision as well as to some particularized instruction on how he or she is to accommodate his or her handicap in practice. For example, and purely by way of my speculative suggestion, practicing solely in conjunction with someone else who is educated to look for the signs of an attack of dementia and warn the handicapped practitioner that a problem is at hand which may cause danger to patients.

Conclusion

The problem of how to deal with the HIV positive health care worker, whether practitioner or student, is most difficult because it is very emotionally charged. The media has done a good job of making people aware of the dangers of AIDS. While that is a positive, it has had the negative result of raising great emotional fears. It is understandable that a person would choose to avoid any risk, no matter how remote, of acquiring the disease. This situation is made more difficult when rational scientific authorities state to the media, and through the media to the public, that they are not certain how HIV infection spreads.

Yet, there are many things known about AIDS and how HIV infection spreads and does not spread. This furnishes the basis for some rational action which will protect the public from real risks and at the same time protect the HIV positive practitioner from irrational restrictions. This paper has tried to work out a construct to permit rational discussion and determinations of what that action should be on a situation by situation basis. While the particular situation that prompted this paper was of a clinical student in an acupuncture college, it is believed that the doctrinal structure is equally applicable to all health care students and practitioners and can provide a valid construct for the resolution of this difficult problem, on a situation by situation basis throughout the health care professions.

Postscript

The number of diagnosed AIDS cases continues to climb. The Centers for Disease Control reports that as of March 31, 1991, 171,876 persons had been diagnosed with AIDS.¹⁴⁹ Some 6,436 of those persons are health care workers. Of those, 47 are surgeons and 171 dentists. Among the others, there are 703 physicians (presumably, other than surgeons), 116 paramedics, 1,358 nurses, 1,101 medical aides, 941 technicians, and 319 therapists.¹⁵⁰ As some estimates of persons who are infected with HIV but are not yet symptomatic for AIDS go as high as 8 times the number of those who have been diagnosed with AIDS, one can easily assume that approximately 45,000 of the 5 million health care workers in the United States are today infected. A current estimate has a mean of 11 years between initial infection with HIV and the development of symptomatic AIDS.¹⁵¹

Various surveys continue to develop data upon which experts render opinions. CDC reported recently that of 3,420 orthopedic surgeons who were tested for HIV, two were found to be positive.¹⁵² The American Dental Association reported three HIV positive dentists out of 6,000 tested.¹⁵³ These figures, of one in 1,710 and one in 2,000, are considerably less than the nine in 1,000 estimated in the general population of health care workers.

Furthermore, more surveys of patients of AIDS-infected dentists and surgeons are available. The number of patients of the Johns Hopkins Hospital surgeon, Dr. Almaraz, who were tested after it was announced that he died of AIDS—and the hospital offered free testing, has climbed to 1,800. The number of patients tested after a Florida orthopedist, Dr. Robert Engel, announced his retirement because of his AIDS infection is 700. No patient of either practitioner has tested positive.¹⁵⁴

Thus, although now several thousand patients of HIV-infected surgeons and dentists have been tested, there are a total of five patients who apparently have been HIV-infected from a health care worker. All five were infected through a single dentist, Dr. David Acer.¹⁵⁵ Dr. Acer was first diagnosed with symptomatic HIV infection in late 1986 and with AIDS in September 1987.¹⁵⁶ He continued practicing until July 1989.¹⁵⁷ Of Dr. Acer's approximately 2,000 patients, 700 have been tested for HIV, and five have been found positive.¹⁵⁸ No other survey of any infected surgeon or dentist has confirmed any instance of transmission from or through a health care worker to a patient.

As another paper in this Symposium notes, from all of this information,

CDC recently estimated that an HIV-infected surgeon has from 1 in 41,667 to 1 in 416,667 chance of transmitting HIV to his patient. The estimate of an infected dentist transmitting the virus to a patient during a procedure involving a large amount of blood was estimated at 1 in 263,158 to 1 in 2,631,579.¹⁵⁹

Yet, it is under these circumstances that Kimberly Bergalis became symptomatic of AIDS within 2 years of infection, while Dr. Acer was still alive. A sample of Dr. Acer's blood was obtained, and a comparison of the HIV of Kimberly Bergalis and Dr. Acer showed very close DNA sequencing, permitting the conclusion that HIV was transmitted from Dr. Acer to Ms. Bergalis.¹⁶⁰ Perhaps because of facts like these, coupled with the fact noted earlier that the mean between initial infection and the development of symptoms may be as high as 11 years, the CDC now estimates, as Dr. Kuvin reports, that 13 to 128 patients have been infected with HIV from health care workers during the past decade.¹⁶¹

Two recent cases raise additional and very serious questions. Each notes the significance of the four-factor analysis of *School Board of Nassau County v. Arline*.¹⁶² Each appears to give conclusive effect to one of those four factors. One of the cases blows a large hole through the CDC's definition of "invasive procedure," and expands the debate far beyond what had earlier been thought of as a limitation to invasive procedures. The other expands the concept of "harm" so as to threaten to refashion the debate rather dramatically. The importance of these two cases is heightened by the fact that they are the first two cases involving the law applicable to an HIV positive health

care worker, and, as such, will need to be dealt with by all subsequent courts considering this issue.

The first case is the Fifth Circuit's decision in *Leckelt v. Board of Commissioners*.¹⁶³ Kevin Leckelt was a licensed practical nurse working at the Terrebone General Medical Center in Houma, Louisiana. His roommate of some 8 years was diagnosed with AIDS at the medical center. The medical center had an infectious control procedure which was generally applicable to all contagious and infectious diseases. That policy required any employee who had been exposed to any infectious disease to report that fact to the infectious disease officer and, where appropriate, to undergo testing and work restrictions.¹⁶⁴ In accordance with that policy, medical center officials instructed Leckelt to be tested for HIV infection. Leckelt advised the officials that he had already been tested, but he refused to turn the results over to the medical center. Leckelt was then fired for insubordination.

Leckelt sued in federal court, claiming that the medical center had violated his right under Section 504 of the federal Rehabilitation Act not to be discriminated against. The district court rejected that claim, holding that "a hospital has a right to require such testing in order to fulfill its obligation to its employees and to the public concerning infection control and health and safety in general," and, therefore, the medical center "was justified in terminating" Leckelt for insubordination for refusing to provide the results of his HIV antibody test.¹⁶⁵ The court of appeals affirmed.

The court of appeals noted that the hospital's requirements were consonant with CDC and American Hospital Association guidelines that, if a health care worker is exposed to the blood or other bodily fluids of a patient infected with the HIV virus, he or she should be tested by the health care facility and counseled about the risk of infection. Furthermore, these guidelines provide that the facility, in conjunction with the worker's personal physician, should determine how, if at all, the exposed worker's duties should be restricted or modified in order to protect patients from the spread of infection and the health care worker from exposure to other infectious diseases of patients.¹⁶⁶ The court also referred to the fact that Leckelt earlier had a medical history of hepatitis B, syphilis, and lymphadenopathy, and had not reported at least some of these facts to the medical center, as was required by the medical center's universal procedures.¹⁶⁷

The court attempted to draw its holding narrowly, concluding

that the district court was not clearly erroneous in finding that Leckelt was not "otherwise qualified" to perform his job as a licensed practical nurse because of his failure to comply with [the medical center's] policies for monitoring infectious disease, such as HIV.¹⁶⁸

While willful failure to follow a hospital's reasonable infectious disease procedures is an unexceptional ground for discipline, even termination, of a health care worker, the expressed reasoning of the Fifth Circuit in applying this principle to the facts in *Leckelt* raises some significant questions in terms of the assumptions of the ongoing debate. For example, the court noted that *Arline* presented a four-factor analysis—(a) the nature of the risk; (b) the duration of the risk; (c) the severity of the risk; and (d) the probabilities that the disease will be transmitted—and, furthermore, that *Arline* referred expressly to a "significant risk" of transmittal.¹⁶⁹ Then the Fifth Circuit rejected Leckelt's argument that he posed no significant risk to patients, because in the case of HIV infection "there is no cure . . . and the potential harm of HIV infection is extremely high."¹⁷⁰

Thus, the Fifth Circuit appears to be saying that, if the third *Arline* factor—the severity of the risk—is certain death, the fact that "the probability that a health care worker will transmit HIV to a patient may be extremely low and can be further minimized through the use of universal precautions" is immaterial.¹⁷¹ The necessary implication of that reasoning is that, since HIV disease is invariably fatal based upon present knowledge, even the most remote chance of transmittal is enough to justify severe restrictions or even termination of a health care worker.

Leckelt also argued that he did not perform invasive procedures as defined by the CDC, and, indeed, the Fifth Circuit so found.¹⁷² However, the Fifth Circuit went on to find that "at least some of [Leckelt's] duties provided potential opportunities for HIV transmittal to patients."¹⁷³ Thus, the Fifth Circuit appears to be expanding the CDC's concept of "invasive procedures" to include any procedure that would permit HIV transmittal to a patient should the health care worker bleed into any opening in the patient's skin. The procedures referred to—starting intravenous interventions, injecting medication, performing catheterization, changing dressings, and administering enemas—include procedures performed by most, if not all, nurses, physician assistants, paramedics, health aides, and the like.

Finally, in response to Leckelt's argument that a nurse who followed universal precautions was "little to no risk" to his or her patients, the Fifth Circuit pointed to testimony that "approximately 5 to 10% of the time health care workers do not comply with recommended universal precautions."¹⁷⁴ The Fifth Circuit referred to (a) testimony of a hospital patient that, in January 1984, Leckelt had not worn gloves while ministering to her, and (b) the fact that Leckelt had not reported all of his personal infections to the hospital's infectious disease officer in violation of clear hospital policy.¹⁷⁵

When these two strands of reasoning are combined, the debate is completely altered. The debate up to now has been over the HIV positive surgeon or dentist whose hand or finger is in an open wound or

cavity of a patient, in a location where there are sharp instruments that can cut the health care worker in such a manner that the health care worker will bleed into the open wound or cavity before he or she has a chance to remove the injured hand or finger. To date, the debate has been as to whether such a surgeon or dentist should continue practicing surgery or dentistry without a specific showing that that person is not practicing proper hygienic procedures and so is a "significant risk" of transmitting HIV disease.¹⁷⁶

The Fifth Circuit's reasoning would not limit a hospital or clinic from firing or restricting solely HIV positive persons who engage in invasive procedures, as previously understood, but would extend them to any HIV positive health care worker who is engaged in any activity that causes, or is over or around, any opening in the skin of the patient, and who, by any remote possibility, might bleed into the opening. Moreover, even assurances by the health care worker that he or she would follow universal precautions would not be enough, if the hospital believes that a sufficient percentage of time health care workers do not follow such procedures. If this reasoning is followed by other courts, the debate is significantly altered and the four-fold analysis of *Arline* would appear to be all but inoperable in the case of HIV-infected health care workers.

The other recent development is a decision by the New Jersey Superior Court in *Behringer v. Medical Center at Princeton*.¹⁷⁷ This case, too, raises questions that will change the terms of the debate. Dr. William Behringer, an otolaryngologist (ear, nose, and throat surgeon) and a plastic surgeon, a member of the staff of the medical center, was diagnosed as suffering from AIDS. The medical center at first suspended Dr. Behringer, and then permitted him to practice surgery only with the consent of patients who had first been told specifically that Dr. Behringer had AIDS. His practice dried up. Dr. Behringer sued, claiming that the medical center had violated his rights under the New Jersey Law Against Discrimination. Apparently, no violation of federal statutory rights were alleged.

Superior Court Judge Carchman first held that Dr. Behringer, as an HIV-infected person, was handicapped within the meaning of the New Jersey Law and, hence was protected by it.¹⁷⁸ However, the court then upheld the medical center's action, holding that it was "substantially justified by a reasonable probability of harm to the patient."¹⁷⁹

Judge Carchman noted the medical center's concession that their only reason for restricting Dr. Behringer's practice was his positive AIDS diagnosis, and that this constituted a prima facie case of discrimination under the New Jersey Law. The burden then shifted to the medical center to show that Dr. Behringer posed a "reasonable probability of substantial harm" to others"; the medical center had

the burden of "establish[ing] with a reasonable degree of certainty that it reasonably arrived at

the opinion that the employee's handicap presented a materially enhanced harm in the workplace."¹⁸⁰

The court noted that the medical center had made "painstaking inquiries" into what was right, referring to many existing guidelines and the literature of the time. The medical center concluded that, if a physician poses "any risk" of harm, it was enough to preclude the procedure.¹⁸¹ The court concluded that reasonable persons may differ as to "whether there is 'any' risk involved," but that, if the procedure transmitted HIV disease, it would lead to the death of the patient. But, the court went on, the decision would also need to consider that the resulting denial of practice would affect the physician's ultimate ability to practice his or her chosen profession.¹⁸²

To reach a solution, the court concluded, one must look to the doctrine of informed consent, which "provides the necessary element of patient control . . ." This doctrine protects the patient's "right to self-determination in matters of medical treatment." As a part of the informed consent requirement, the physician has the duty "to explain, in words the patient can understand, that medical information and those risks which are material" (i.e., those to which "a reasonable patient would be likely to attach significance . . . in deciding whether or not to submit to the treatment").¹⁸³

The risk, however, was held to be *not* the risk of transmission of HIV *alone*. Rather, the court found, wherever the HIV positive physician suffers a needle-stick or cut, the previously uninfected patient will need to undergo "months or even years of continual HIV testing." The court quoted from the literature that:

Studies indicate that a surgeon will cut a glove in approximately one out of every four cases, and probably sustain a significant cut in one out of every forty cases.¹⁸⁴

Thus, the harm that a patient risks from an HIV-infected surgeon is not limited to transmission alone, the risk of which the court conceded was "small" and "may be reduced by the use of universal precautions."¹⁸⁵ But the harm that a patient risks also includes

HIV testing over an extended period with the attendant anxiety of waiting for test results, and the possible alterations to lifestyle and child-bearing during the testing period, even if those results ultimately are negative.¹⁸⁶

This was a risk which, from studies done, Professor Gostin estimated would become real in 2.5% of the operations performed by an HIV positive surgeon. Based on these facts, the court concluded:

In assessing the "materiality of risk," this Court concludes that the risk of accident and implications thereof would be a legitimate concern to the surgical patient, warranting disclosure of this risk in the informed consent setting.

When weighing the patient's right to know as against the physician's right to continuing practice, "the patient's rights must prevail" under New Jersey's "strong policy supporting patient's rights . . ." ¹⁸⁷

At a minimum, the physician must withdraw from performing any invasive procedure which would pose a risk to the patient. Where the ultimate harm is death, even the presence of a low risk of transmission justifies the adoption of a policy which precludes invasive procedures when there is "any" risk of transmission If there is to be an ultimate arbiter of whether the patient is to be treated invasively by an AIDS positive surgeon, the arbiter will be the fully informed patient. The ultimate risk to the patient is so absolute—so devastating—that it is untenable to argue against informed consent combined with a restriction on procedures which present "any risk" to the patient. ¹⁸⁸

Judge Carchman thus shares with the Fifth Circuit in *Leckelt* the opinion that, because the result of AIDS infection is certain death, the "severity of the risk" factor of *Arline* overwhelms the other factors in the analysis. But, by expanding the concept of harm to include the necessity of testing, the anxiety, and the impact upon the life of the patient who ultimately tests negative, Judge Carchman changes the debate substantially—even under the *Arline* analysis. Now, it is no longer the 1 in 41,667 to 1 in 416,667 (surgeon) or 1 in 263,158 to 1 in 2,631,579 (dentist) risk of doing harm (i.e., transmission of HIV infection reported by Drs. Pierce, Fisher, and Rabin elsewhere in this Symposium as CDC's recent estimate). Now it is the 1 in 40 risk of a significant cut in the surgeon reported by Professor Gostin which triggers harm even in the overwhelming instances where the patient is ultimately found not to have contracted the disease.

Read together, *Leckelt* and *Behringer* will change the terms of the debate rather significantly. They make even more urgent the agreement of an analytical framework within which to evaluate the rights of all concerned. The failure to do so may result in the banishment of the now 40,000 to 50,000 health care workers who are unfortunate enough to have become infected, depriving them of their livelihood and society of their services for several years between infection and death. To subject the Kimberly Bergalises of tomorrow to any realistic risk of becoming infected is a wrong. To subject others, although ultimately proven negative, to the months and even years of testing, anxiety, and significant impact upon their lifestyles is a wrong. But to banish tens of thousands of trained, willing workers where, in the real world, they provide no realistic risk, is also wrong. The line must be found that will reconcile each of these values in a way valid in science, in law, and in humaneness to all concerned.

The most appropriate analytical framework is one that looks at the risk in reality, not one perceived in emotion, bias, and prejudice. There is always some

risk. If a person rides a bus and an HIV positive fellow passenger suddenly cuts himself, spewing blood into an open sore of his neighbor, there is a risk of transmittal of HIV disease. The same risk is present when one walks on the street, shops in a store, etc. Life is not without such risks. Thus, to take what appears to be an extreme in the health care worker, if one is a patient of a psychiatrist, who normally does no more than shake hands and listen, and that psychiatrist bumps his head, spewing blood into an open sore of the patient, there is a risk of transmittal. But in each one of these situations, the risk is remote, at best.

The analytical framework that appears best to reconcile all of the competing values is one that looks at risk in a real situation. As the surgeon, we are told by studies, significantly cuts him or herself once in every 40 procedures while within a cavity or wound of the patient, there is a real risk of harm, with a significant incidence of occurrence—as long as harm is looked at as broader than transmission, to include the need for testing, the anxiety, and the effect on the life of the person who ultimately tests negative. On the other hand, if the health care worker is not involved in such a risky procedure, then the risk may be no greater than highly remote. The evaluation must be made on a position by position basis, and must focus upon actual risk as provided by the science of the time. Any other solution is one based upon emotion, bias, and prejudice either for or against one of the actors in this tragic drama. That cannot be the law.

Where there is real risk, the question often asked is whether informed consent should be sought. But that seems to be the wrong question. Where there is real risk, the consent of the patient should not be able to override what should be the better judgment of the practitioner: don't do it. Clearly, the patient should not be asked to consent to malpractice. And placing a patient under a real risk situation, even with his or her consent, just cannot be good health practice.

Upon this analysis, the result in *Behringer* seems right, although the ambivalence of Judge Carchman at the end of the opinion concerning the use of informed consent would appear to be wrong. The reasoning in *Leckelt*, on the other hand, appears to be wrong. That a nurse does change dressings, administer intravenous therapy, etc., does not put the nurse into a cavity or open wound of the patient where there are sharp instruments on which a nurse is wont to cut him or herself. Nor does the Fifth Circuit attempt to justify its reasoning on those grounds.

It is very easy, with a disease as emotionally charged as HIV, to fear that whenever a person who is HIV positive is near a patient who has some opening through his skin, somehow some blood of the HIV positive person will get into that opening, thus transmitting HIV. While no one can ever ensure or guarantee that that will not happen to some person someday, no such guarantee can be given in all of the other contacts of daily living. The question is not whether

anyone can guarantee that it will never happen but whether, based upon the science of the time, there is any real risk of it happening. Therein should lie the framework of an analysis across the spectrum of the HIV positive health care worker.

Finally, *Leckelt* and *Behringer* have one more factor in common: each looks to the institution primarily for the decision. In each case, the court notes how the institution worked diligently to find the right result, drawing upon the guidelines issued by professional groups such as the CDC and the American Hospital Association. While the decision of the institution is not given unfettered rein, that decision, arrived at through rational exploration and consonant with the thought-through positions of recognized organizations, is given much deference in each case. And that is as it should be. Whether the institution is the academy or a hospital or clinic, the ultimate decision should be that of the professionals in the institution. And, as long as the decision of the institution is rationally based, gives due regard for the various values involved, and tramples on no rights arbitrarily, that decision should be upheld.

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Endnotes

1. Rehabilitation Act of 1973, Sec. 2, 29 U.S.C. 701.
2. *Id.*, at Sec. 504, 29 U.S.C. 794.
3. *Martin v. Delaware Law School*, 625 F.Supp. 1288 (D.Del. 1985).
4. *Bachman v. American Society of Clinical Pathologists*, 577 F.Supp. 1257 (D.N.J. 1983).
5. See *Chaplin v. Consolidated Edison Co.*, 628 F.Supp. 143 (S.D.N.Y. 1986).
6. *U.S. v. Baylor University Medical Center*, 736 F.2d 1039 (5th Cir. 1984).
7. *U.S. v. University Hospital of State University*, 575 F.Supp. 607 (E.D.N.Y.) aff'd 729 F.2d 144 (2d Cir. 1984).
8. *Glanz v. Vernick*, 750 F.Supp. 39, 756 F.Supp. 632 (D.Mass. 1990, 1991).
9. Department of Justice, (1977) (Counsel-Inf.Op.) 1 Op. Office of Legal Counsel 210; see also 34 C.F.R. Sec. 104.3(f).
10. *Supra*, note 1 at 29 U.S.C. 706(8) (B).
11. *School Board of Nassau County v. Arline*, 107 S.Ct. 1123 (1987).
12. *Id.*, at 1130.
13. *Supra*, note 1 at 29 U.S.C. 706(8) (C).
14. *Supra*, 07 S.C.C. at 1132-1133.
15. See, e.g., 134 Cong. Rec. S1739 (March 2, 1988) and H1065 (March 22, 1988) (Sen. Harkin); *id.* at H572 (March 2, 1988) (Rep. Weiss) ("with this amendment [Congress is] stating clearly that individuals with contagious diseases or infections are protected under the statute . . ."); *id.* at H574 (Rep. Owens) ("I am glad to see that [the amendment] refers to individuals with contagious infections, thus clarifying that such infections can constitute a handicapping condition under the Act."); *id.* at H560-61 (Mar. 2, 1988) (Rep. Coelho) (the amendment "provides that individuals with contagious diseases or infections are protected under the statute").
16. *Chalk v. U.S. District Court*, 840 F.2d 701 (9th Cir. 1987); *Doe v. Dolton Elementary School District*, 694 F. Supp. 440 (N.D.Ill. 1988); *Ray v. School District*, 666 F.Supp. 1524 (M.D.Fla. 1987); *Thomas v. Atascadero Unif. School District*, 662 F.Supp. 376 (C.D. Cal. 1987); *Local 1812 v. U.S. Department of State*, 662 F.Supp. 50, 54 (D.D.C. 1987); *District 27 Community School Board v. Board of Education*, 502 N.Y.S.2d 325 (Sup.Ct. 1985).
17. See, e.g., 134 Cong. Rec. H573 (March 2, 1988) (Rep. Weiss) (the amendment makes clear that Congress intends the Act to apply to "individuals with contagious diseases or infections . . . such as carriers of the AIDS virus or carriers of the hepatitis B virus . . ."); *id.* at H560-61 (Rep. Coelho) (the amendment clarifies that the Act applies to "people with infectious diseases and infections, such as people with AIDS or people infected with the AIDS virus"); *id.* at H584 (Rep. Edwards); *id.* at E487 (Rep. Hoyer). Even the opponents of the amendment conceded the point. See, e.g., *id.* at H580 (Rep. Dannemeyer).
18. Koop letter to acting Attorney General, Office of Legal Counsel, dated July 29, 1988.
19. 45 C.F.R. Sec. 4.3(j) (2) (i) (1987).
20. Op. Assistant Attorney General, Office of Legal Counsel, dated September 27, 1988, pp. 9-11.
21. *Supra*, note 1, at 29 U.S.C. 706(8) (B) (iii).
22. S.Rep.No. 1297, 93rd Cong., 2d Session 64 (1974).
23. 107 S.Ct., at 1129.
24. *Id.* at 1126-1127, relying on and quoting *Southeastern Community College v. Davis*, 442 U.S. 397, 405-406 n.6 (1979).
25. *Id.* at 1129.
26. *Local 1812 v. U.S. Dept. of State*, 662 F.Supp. 50, 54 (1987); *Doe v. Centinela Hospital*, 1988 West Law 81776 (C.D. Cal., unreported) (a person is an "individual with handicaps" if he "has a physiological disorder or condition affecting a body system that substantially limits a 'function' only as a result of the attitudes of others toward the disorder or condition . . ."). The HHS regulations are in accord with this view. 45 C.F.R. sec. 84.3(j) (2) (iv) (B) (1987).
27. *Southeastern Comm'y College v. Davis*, 442 U.S. at 406.
28. 107 S.Ct., at 1131.
29. *Id.*, at 1131.
30. *Id.*, at 1131 and n.17, quoting *Southeastern Comm'y College*.
31. *Id.*, at 1131 n.16.
32. See U.S. Department of Health and Human Services, Surgeon General's Report on Acquired Immune Deficiency Syndrome, 12, 32 (1986).
33. *Supra*, note 1, 29 U.S.C. 706(8) (C).
34. See, e.g., 134 Cong. Rec. S1740 (Mar. 2, 1988), H1065 (Mar. 22, 1988), and S2435 (Mar. 17, 1988) (Sen. Harkin); *id.* at H573 (Rep. Weiss); *id.* at H575 (Rep. Waxman); *id.* at E501 (Rep. Miller); *id.* at H584 (Rep. Edwards); *id.* at H561 (Rep. Coelho); *id.* at E487 (Rep. Hoyer); *id.* at 571 (Rep. Jeffords).
35. See, e.g., *id.*, at H580 (Rep. Dannemeyer); *id.* at S2403 (Sen. Hatch); *id.* at S2410 (Sen. Symms).
36. Americans with Disabilities Act, 42 U.S.C.A. 12102(2) (Dec. 1990 Pam.).
37. *Id.*, at 12101.
38. *Id.*, at 12111(9), (10), 12112(b).
39. *Id.*, at 12181(7).
40. *Id.*, at 12182(a).
41. *Id.*, at 12182(b) (1) (A).
42. *Id.*, at 12182 (b) (2) (A).
43. *Id.*, at 12182(b) (3).
44. Md. Regs. 14.03.02.02.
45. Md. Regs. 14.03.02.03C.
46. Md. Regs. 14.03.02.05B.
47. Md. Regs. 14.03.02.07.
48. Howard County Code, Section 12.200-.218.
49. *Id.*, Sec. 12.200 Paragraphs I, II.
50. *Id.*, at Paragraph XI.
51. Howard County Human Rights Committee, case no. 90-001-002.
52. *Schloendorff v. Society of New York Hosp.*, 211 N.Y. 125, 105 N.E. 92, 93 (1914).
53. *Sard v. Hardy*, 379 A.2d 1014, 1019 (Md. 1977); *Mohr v. Williams*, 95 Minn. 261, 104, N.W. 12, 15 (1905).
54. *Canterbury v. Spence*, 464 F.2d 772, 781 (D.C. Cir. 1972).

55. *Id.*
56. *Id.*, at 783.
57. *Sard v. Hardy*, 379 A.2d, at 1019.
58. Citing *Natason v. Kline*, 186 Kan. 393, 350 P.2d 1093, 1106 (1960); *Scaria v. St. Paul Fire and Marine Insurance*, 68 Wis.2d 1, 227 N.W.2d 647, 653 (1975).
59. *Sard v. Hardy*, 379 A.2d, at 1020.
60. *Starnes v. Taylor*, 272 N.C. 386, 158 S.E.2d 339, 344 (1968).
61. *Sard v. Hardy*, 379 A.2d, at 1021.
62. 486 F.2d at 786-787.
63. *Sard v. Hardy*, 379 A.2d at 1021. Other jurisdictions that have adopted this standard include the District of Columbia, *Cantebury v. Spence*; California, *Cobbs v. Grant*, 104 Cal.Rptr. 505, 502 P.2d 1 (1972); Massachusetts, *Harnish v. Childrens Hosp. Med. Cent.*, 387 Mass. 152, 439 N.E.2d 240 (1982); New York, *Fogel v. Genesee Hosp.*, 41 A.D.2d 468, 344 N.Y.S.2d 552 (1973); Washington, *Miller v. Kennedy*, 11 Wash.App. 272, 522 P.2d 852 (1974), *aff'd* 85 Wash.2d 151, 530 P.2d 334 (1975); and Wisconsin, *Scaria v. St. Paul Fire & Marine Ins.*, 68 Wis.2d 1, 227 N.W.2d 647 (1975). An article lists 23 states and the District of Columbia as currently having this standard. *Physician's Duty To Inform of Risks*, 88 ALR 3d 1008, 1034, and 1989 Supp.
64. *Sard v. Hardy*, 379 A.2d, at 1021, 1022.
65. *Id.*, at 1022.
66. *Id.*
67. *Wilkinson v. Vesey*, 110 R.I. 606, 624, 295 A.2d 676, 687 (1972).
68. *Precourt v. Frederick*, 395 Mass. 689, 694-695, 481 N.E.2d 1144, 1148 (1985).
69. Gostin, (Jan/Feb 1989). HIV-Infected Physicians and the Practice of Seriously Invasive Procedures, *Hasting Center Report*, 33.
70. *Sard*, 379 A.2d, at 1022.
71. *Id.*
72. *Precourt v. Frederick*, 395 Mass. 689, 694-95, 481 N.E.2d 1144, 1148 (1985).
73. *Kissinger v. Lofgren*, 836 F.2d 678, 681 (1988), quoting *Precourt*; see *Hondroulis v. Schuhmacher*, 546 So.2d 466, 471 (La. 1989), and 553 So.2d 398, 405 (La. 1988).
74. *Id.*
75. *Id.*
76. 464 F.2d at 783 n.36.
77. *Id.*, at 787.
78. *Id.*
79. *Id.*, quoting from *Waltz & Scheuneman*, (1970) *Informed consent to therapy*, 64. *Northwestern University Law Review*, 628, 640.
80. *Id.*, at 787-788.
81. *Id.*, at 789.
82. *Sard v. Hardy*, 379 A.2d, at 1020.
83. *Id.*, at 1021.
84. *Id.*, at 1022.
85. *Wachter v. U.S.*, 877 F.2d 257 (1989).
86. *Id.*, at 258 and n.3.
87. *Id.*, at 261.
88. *Piper v. Menifer*, 51 Ky. 465 (1851).
89. *Id.*, at 468.
90. See *Haas v. Tegtmeier*, 128 Ill.App. 280 (1906).
91. *Hales v. Pittmen*, 118 Ariz. 305, 576 P.2d 493 (1978).
92. *Rossi v. Almaraz and Johns Hopkins Hospital*, no. CL123396 (filed Dec. 10, 1990).
93. *Estate of Behringer v. Medical Center*, no. L88-2550, Mercer County, NJ.
94. *Doe v. Washington University*, no. 88-2509-C-4 (E.D. Mo).
95. Physicians and acquired immunodeficiency syndrome. 262, *Journal of the American Medical Association* (1989).
96. *Supra*, note 69 at 32, citing *Medical Staff News*, p. 2 (1987 August).
97. See *Sard v. Hardy*, 379 A.2d at 1023.
98. 107 S.Ct. 1123 (1987).
99. *Id.*, at 1131.
100. *Id.* (emphasis added).
101. *Id.*, at 1131 n.16. (emphasis added).
102. *Martinez v. School Board*, 861 F.2d 1502 (11th Cir. 1988); *Glover v. Eastern Nebraska Comm'y Office of Retardation*, 867 F.2d 461 (8th Cir. 1989); *Thomas v. Atascadero Unified School Dist.*, 662 F.Supp. 376 (C.D.Cal. 1987).
103. See, e.g., H.Rep. 100-485, Part 3, p. 45, and Part 2, pp. 73-74, 101st Cong., 2d Sess. (1988).
104. Keyes, (1990) Health care professionals with AIDS, 16 *Journal of College and University Law*, 589, 600-601 (footnotes omitted). Dr. Keyes, a professor at the School of Dentistry, West Virginia University, footnotes extensively to the medical literature.
105. *Supra*, note 69, at 32-33.
106. *Supra*, note 104.
107. See 313 *New England Journal of Medicine*, 1017 (Oct. 1985) (400 former patients of surgeon matched with reported names of HIV positive individuals; no matches found); *Journal of the American Medical Association*, 264, 467 (July 25, 1990) (616 former patients of surgeon tested; one was positive but was also an IV drug user who had frequent sexual encounters with prostitutes, and indications of pre-surgery infection; 2160 former patients matched; no matches found); *Military Medicine*, 152, 414 (Aug. 1987) (75 former patients of surgeon tested, all negative); *The Lancet*, 335, 113 (Jan. 13, 1990) (76 former patients tested, but all within 90 days of surgery; all negative); *Morbidity and Mortality Weekly Report*, 30, 492 (July 27, 1990) (possible transmission from a dentist to one patient); *Journal of the American Medical Association*, 264, 1464 (Sep. 19, 1990) (questioning whether in fact there was transmission from the dentist to the patient).
108. *Supra*, note 36, 42 U.S.C.A. 12182(b) (2) (A).
109. *Southwestern Comm'y College v. Davis*, 442 U.S. 397 (1979).
110. *Id.*
111. *Anderson v. University of Wisconsin*, 841 F.2d 737 (1988).
112. *Doe v. New York University*, 666 F.2d 761 (1981).
113. *Doherty v. Southern College of Optometry*, 862 F.2d 570 (1988).
114. See *Navia & Price*. (1987). The acquired immunodeficiency syndrome dementia complex as the presenting or sole manifestation of human immunodeficiency virus infection. *Archives of Neurology*, 44, 65.
115. *Sweezy v. New Hampshire*, 354 U.S. 234, 263 (1957), quoting with clear approval a statement of a conference of senior scholars from South African universities.
116. See *Byrne*, Academic freedom: A special concern of the first amendment. 99, *Yale Law Journal*, 251, 278-279 (1989).
117. *Sweezy v. New Hampshire*, 354 U.S., at 250, 251.
118. *Id.*, at 262.
119. *Kayishian v. Board of Regents*, 385 U.S. 589 (1967).
120. *Id.*, at 603.
121. *Regents of California v. Bakke*, 438 U.S. 265 (1978).
122. *Id.*, at 312.
123. *Id.*, at 311-319.
124. *Id.*, at 312.
125. *Board of Curators, University of Missouri v. Horowitz*, 435 U.S. 78 (1978).
126. *Regents of University of Michigan v. Ewing*, 474 U.S. 214 (1985).
127. *Id.*, at 226, quoting from *Kayishian*, 385 U.S. at 608.
128. Citing: "see *Keyishian v. Board of Regents*, 385 U.S., at 603; *Sweezy v. New Hampshire*, 354 U.S. 234, 250 (opinion of Warren, C.J.)."
129. Citing: "see *University of California Regents v. Bakke*, 438 U.S. 265, 312 (1978) (opinion of Powell, J.); *Sweezy v. New Hampshire*, 354 U.S., at 263 (Frankfurter, J., concurring in result)."
130. *Ewing*, 474 U.S. at 226 n.12, citing *Bakke*, 438 U.S. at 312.
131. *Ewing*, 474 U.S. at 225.
132. *Horowitz*, 435 U.S. 125, at 96 n.6 (Powell, J., concurring), 90-92; quoted in *Ewing*, 474 U.S. at 225 n.11; see also opinion of the Court in *Horowitz*, 435 U.S. at 90-92.
133. *University of Pennsylvania v. Equal Employment Opportunity Commission*, 110 S.Ct. 577, 587 (1990).
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162. 107 S.Ct. 1123, 1131 (1987).
163. *Leckelt v. Board of Commissioners*, 909 F.2d 820 (5th Cir. 1990).
164. *Id.*, at 826.
165. *Leckelt*, 714 F.Supp. 1377, 1379 (E.D.La. 1989).
166. 909 F.2d. at 830.
167. *Id.*
168. *Id.*
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